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UNITED STATES DISTRICT COURT NORTHERN DISTRICT OF CALIFORNIA SAN FRANCISCO DIVISION

DAVID AND NATASHA WIT, et al.,

Plaintiffs,

v.

UNITED BEHAVIORAL HEALTH (operating as OPTUMHEALTH BEHAVIORAL SOLUTIONS),

Defendant.

GARY ALEXANDER, et al.,

Plaintiffs,

v.
UNITED BEHAVIORAL HEALTH
(operating as OPTUMHEALTH
BEHAVIORAL SOLUTIONS),

Defendant.

Case No. 3:14-CV-02346-JCS Action Filed: May 21, 2014

PLAINTIFFS' CLAIMS CHART: CHALLENGED UBH GUIDELINE PROVISIONS

Case No. 3:14-CV-05337-JCS Action Filed: December 4, 2014

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I. <u>INTRODUCTION</u>

The following chart identifies each distinct provision in UBH's Level of Care Guidelines, from 2011 through 2017, that Plaintiffs contend falls short of generally accepted standards of care, notes the reasons supporting Plaintiffs' contention, and cites the evidence on which Plaintiffs rely with respect to that particular provision. The chart also catalogues the same information with respect to each version of UBH's Custodial Care Coverage Determination Guideline in effect from 2011 to 2017.

Plaintiffs' Post-Trial Brief ("Br.") and Proposed Findings of Fact ("PFF") explain and catalog the evidence showing the many ways the specific challenged provisions make these Guidelines more restrictive than generally accepted standards of care. *See* Br. § II.G, PFF § IX. The chart below incorporates both of those filings. Specifically, in the "Why Flawed" column, several of the flaws discussed in detail in the Brief and Proposed Findings of Fact are referenced using "short forms" and cross-references to the other filings, as follows:

Flaw category	"Why Flawed" Column
Overemphasis on Acuity	Acuity (see Br. § II.G.1; PFF
	§ X.A)
Failure to Consider Effective Treatment of Co-Occurring	Co-occurring (see Br. § II.G.2;
Conditions	PFF § X.B)
Drive Toward Lower Levels of Care Rather than Erring	Drive Toward Lower Levels of
on the Side of Caution	Care (see Br. § II.G.3; PFF §
	X.C)
Preclusion of Coverage for Treatment to Maintain a Level	Maintenance of Function (see
of Function	Br. § II.G.5; PFF § X.E)
Lack of Motivation is Grounds for Denying Coverage,	Motivation (see Br. § II.G.6;
Even Where the Member has the Capacity to Recover	PFF § X.F)
Overbroad Definition of Custodial Care and Overly	Custodial/Improvement (see Br.
Narrow View of Improvement and Active Treatment	§ II.G.8; PFF § X.H)

In addition, however, it is important to note that Plaintiffs challenge the Guidelines for reasons that are not expressly reflected on the chart below:

First, Plaintiffs challenge the Guidelines because of omissions that render the criteria, as a whole, incompatible with generally accepted standards of care. One of these omissions – the Guidelines' failure to consider effective treatment of co-occurring conditions – relates in part to existing Guideline provisions and, therefore, is referenced below. But the failure to provide for coverage at a level of care at which co-occurring conditions can be effectively treated is an omission that, apart from any specific provision, causes the Guidelines overall to fall short of generally accepted standards.

Similarly, there are two flaws in the Guidelines that do not correspond directly to any existing provisions: (1) the Guidelines' use of mandatory prerequisites for coverage, rather than ensuring that level of care decisions turn on a multi-dimensional assessment of each patient, Br. § II.G.4; PFF § X.D; and (2) the Guidelines' failure to address the unique needs of children and

adolescents, Br. § II.G.7; PFF § X.G. Plaintiffs do not cite those flaws in the chart below because they apply, in effect, to every provision in every year.

Second, the sections in the Level of Care Guidelines that set forth additional criteria for coverage at specific levels of care also incorporate the Common Criteria, either explicitly or implicitly. Thus, in each year, for coverage upon admission and for coverage of continued services, members must have satisfied the Common Criteria. *See*, *e.g.*, Ex. 4-0027 ("(See Common Criteria for all Levels of Care)"); Ex. 1-0078 (¶ 1) ("The member continues to meet the criteria for the current level of care."). Although not cited on the chart below, Plaintiffs also challenge those sections' provisions incorporating the Common Criteria, for the same reasons that they challenge the Common Criteria.

Third, Plaintiffs also challenge the level of care criteria in the Coverage Determination Guidelines, which incorporate the level of care criteria in the Level of Care Guidelines, in one or (more often) multiple ways. *See* Br. § II.B.2(a); PFF § V.B.

Finally, the omission from the chart below of any particular Guideline provision should not be construed as an admission by Plaintiffs that the provision *is* consistent with generally accepted standards of care. The chart below focuses only on the provisions reflecting defects addressed at trial.

II. 2011 LEVEL OF CARE GUIDELINES (EX. 1)

A. Common Criteria (Ex. 1-0005 to -0008 & Ex. 1-0078 to -0079)

1. Admission Criteria (Ex. 1-0005 to -0008)

¶	Criterion	Why Flawed	Testimony ¹
5	The member's current condition cannot be effectively and safely treated in a	Drive Toward Lower Levels of Care	Fishman: E.g., Tr. 97:10-14 ("[W]hat we
	lower level of care even when the treatment plan is modified, attempts to	(see Br. § II.G.3; PFF § X.C)	want from a level of care placement matching
	enhance the member's motivation have been made, or referrals to community		guideline are decision rules that direct a user
	resources or peer supports have been made.		to place a patient where the treatment will be
			<i>most effective</i> , where the outcomes will be
			best, where their journey of recovery will
			likely be aided in the <i>most successful</i> way.");
			213:6-18 ("what typically drives decisions are
			[what level of care will be] most effective");
			<u>Plakun</u> : <i>E.g.</i> , Tr. 511:25-512:6 ("The more
			important issue is, what's the <i>most effective</i>
			way for this person to get better.").

¹ The evidentiary cites herein do not identify all testimony that pertains to all the *reasons* the identified criterion is flawed; those reasons are explicated in greater detail in the relevant portions of Plaintiffs' Post-Trial Brief ("Br.") and Plaintiffs' Proposed Findings of Fact ("PFF"). Instead, as the Court requested, the "Testimony" column identifies the testimony that specifically pertained to the particular provision being challenged. For example, there was a great deal of testimony regarding why criteria focused on "presenting" and "acute" symptoms and "acute changes" render the Guidelines more restrictive than generally accepted standards of care; Plaintiffs have not repeated citations to all that evidence in every row where a criterion overemphasizes acuity, assuming such duplication would not be of assistance to the Court.

\P	Criterion	Why Flawed	Testimony ¹
6	There must be a reasonable expectation that essential and appropriate services	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 132:13-16, 132:20-133:02;
	will improve the member's presenting problems within a reasonable period of	Maintenance of Function (see Br.	Plakun: Tr. 537:15-18; Niewenhous: Tr.
	time. "Improvement" in this context is measured by weighing the	§ II.G.5; PFF § X.E)	321:01-15, 335:17-25.
	effectiveness of treatment against the evidence that the member's condition		
	will deteriorate if treatment is discontinued in the current level of care.		
	Improvement must also be understood within the framework of the member's		
	broader recovery goals.		
7	The goal of treatment is to improve the member's presenting symptoms to the	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 132:13-16, 133:04-14; <u>Plakun</u> :
	point that treatment in the current level of care is no longer required.	Maintenance of Function (see Br.	Tr. 537:15-18.
		§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
		Lower Levels of Care (see Br.	
		§ II.G.3; PFF § X.C)	
8	Treatment is not primarily for the purpose of providing respite for the family,	Maintenance of Function (see Br.	<u>Fishman</u> : Tr. 133:20-134:22.
	increasing the member's social activity, or for addressing antisocial behavior	§ II.G.5; PFF § X.E);	
	or legal problems, but is for the active treatment of a behavioral health	Custodial/Improvement (see Br.	
	condition.	§ II.G.8; PFF § X.H)	
	The treatment plan stems from the member's presenting condition, and	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 219:12-19.
10	clearly documents realistic and measurable treatment goals as well as the		
	treatments that will be used to achieve the goals of treatment		

2. Continued Service Criteria (Ex. 1-0078 to -0079)

\P	Criterion	Why Flawed	Testimony
2	The member continues to present with symptoms and/or history that	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 136:24-137:9, 137:10-15;
	demonstrate a significant likelihood of deterioration in functioning/relapse if	Drive Toward Lower Levels of Care	<u>Plakun</u> : Tr. 538:1-4.
	transitioned to a less intensive level of care, or in the case of outpatient care,	(see Br. § II.G.3; PFF § X.C)	
	is discharged.		
4	The member is actively participating in treatment or is reasonably likely to	Motivation (see Br. § II.G.6; PFF	Fishman: Tr. 135:10-136:15.
	adhere after an initial period of stabilization and/or motivational support.	§ X.F);	

¶	Criterion	Why Flawed	Testimony
8	Measurable and realistic progress has occurred or there is clear and compelling evidence that continued treatment at this level of care is required to prevent acute deterioration or exacerbation that would then require a higher level of care. Lack of progress is being addressed by an appropriate change in the treatment plan or other intervention to engage the member.	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 136:24-137:9, 137:10-15; Plakun: Tr. 538:1-4, 538:15-539:4, 539:6-8; Simpatico: Tr. 1238:7-1244:5; Niewenhous: Tr. 336:01-337:13 (THE COURT: Where did you get the clear and compelling? THE WITNESS: You know, I honestly don't know where we got that. THE COURT: You didn't get it from Medicare; right? THE WITNESS: No. No.").
10	The member cannot effectively move toward recovery and be safely treated in a lower level of care, or in the case of outpatient care, is discharged.	Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	Fishman: E.g., Tr. 97:10-14 ("[W]hat we want from a level of care placement matching guideline are decision rules that direct a user to place a patient where the treatment will be most effective, where the outcomes will be best, where their journey of recovery will likely be aided in the most successful way."); 213:6-18 ("what typically drives decisions are [what level of care will be] most effective"); Plakun: E.g., Tr. 511:25-512:6 ("The more important issue is, what's the most effective way for this person to get better.").

B. Intensive Outpatient Program: Mental Health Conditions (Ex. 1-0018 to -0020)

¶	Criterion	Why Flawed	Testimony
$[Any] 2^2$	The member's mood, affect or cognition has deteriorated to the extent that a	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 145:8-12, 146:5-13.
	higher level of care will likely be needed if intensive outpatient treatment is		
	not provided.		

² Some LOCG subsections have their own subsections, prefaced by, for example, "Any one of the following criteria must be met" and "And all of the following..." *See, e.g.*, Ex. 1-0018. On the Claims Chart, "[Any] __" refers to paragraphs within the latter section. *See also* Br. at 61 n.41 (explaining

¶	Criterion	Why Flawed	Testimony
[All] 3	Co-occurring substance use disorders, if present, can be treated in a dual	Co-occurring (see Br. § II.G.2; PFF	Fishman: Tr. 107:20-108:24; Plakun: Tr.
	diagnosis program, or can be safely managed at this level of care.	§ X.B)	526:14-16.
[All] 7	The provider and, whenever possible, the member collaborate to update the	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 571:3-6, 571:12-572:5.
	treatment plan every 3 to 5 treatment days in response to changes in the	Drive Toward Lower Levels of Care	
	member's condition, or provide compelling evidence that continued treatment	(see Br. § II.G.3; PFF § X.C)	
	in the current level of care is required to prevent acute deterioration or		
	exacerbation of the member's current condition.		

C. Outpatient: Mental Health Conditions (Ex. 1-0021 to -0022)

\P	Criterion	Why Flawed	Testimony
[All] 3	Co-occurring substance use disorders, if present, are stable and are unlikely	Co-occurring (see Br. § II.G.2; PFF	Fishman: Tr. 107:20-108:24; Plakun: Tr.
	to undermine treatment of the mental health condition at this level of care.	§ X.B)	526:14-16.
[Consider]	The member refuses further treatment or repeatedly does not adhere with	Motivation (see Br. § II.G.6; PFF	<u>Fishman</u> : Tr. 236:12-237:4, 135:10-136:15.
2	recommended treatment despite the deployment of motivational	§ X.F);	
	enhancement interventions, peer support and other community support		
	services. In such cases, the provider explains the risks of discontinuing		
	treatment to the member and, as appropriate, the member's family/social		
	supports; alternative referrals are provided in writing; and the member is		
	provided with instructions for resuming services should the need arise in the		
	future.		

why flaws in the "Any <u>ONE</u>" sections render the Guidelines more restrictive even though not *all* of them must be satisfied for coverage). In one instance, the subsection begins with "Consider." Ex. 1-0022.

D. Residential Treatment Center: Mental Health Conditions (Ex. 1-0026 to -0028)

\P	Criterion	Why Flawed	Testimony
[Any] 2	The member is experiencing a disturbance in mood, affect or cognition	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 572:12-573:16.
	resulting in behavior that cannot be safely managed in a less restrictive	<u>Drive Toward Lower Levels of Care</u>	
	setting. (This criterion is not intended for use solely as a long-term solution to	(see Br. § II.G.3; PFF § X.C);	
	maintain the stabilization acquired during treatment in a residential	Maintenance of Function (see Br.	
	facility/program.)	§ II.G.5; PFF § X.E)	
[Any] 3	There is an imminent risk of deterioration in the member's functioning due to	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 572:12-13, 572:16-17, 573:3-16.
	the presence of severe, multiple and complex psychosocial stressors that are	<u>Drive Toward Lower Levels of Care</u>	
	significant enough to undermine treatment at a lower level of care. (This	(see Br. § II.G.3; PFF § X.C);	
	criterion is not intended for use solely as a long-term solution to maintain the	Maintenance of Function (see Br.	
	stabilization acquired during treatment in a residential facility/program.)	§ II.G.5; PFF § X.E).	
[All]	Within 48 hours of admission, the following occurs:	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 142:15-143:10; <u>Alam</u> : Tr.
2(a)	a. A psychiatrist completes a comprehensive evaluation of the member.		1586:19-1587:21 (conceding that residential
			treatment does not "require[] a physician to
			do anything like what – to do what is required
			by the Level of Care Guidelines").
[All] 3	Subsequent psychiatric evaluations and consultations are available 24 hours a	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 142:15-143:10; <u>Alam</u> : Tr.
	day. Visits with the treating psychiatrist occur at least 2 times per week.		1586:19-1587:21.
[All] 4	All relevant general medical services, including assessment and diagnostic,	Co-occurring (see Br. § II.G.2; PFF	<u>Fishman</u> : Tr. 221:23-223:23.
	treatment, and consultative services are available as needed and provided with	§ X.B)	
	an urgency commensurate with the member's medical need. Co-occurring		
	medical conditions can be safely treated in this level of care.		

E. Intensive Outpatient Program: Substance Use Disorders (Ex. 1-0042 to -0045)³

¶	Criterion	Why Flawed	Testimony
[Any] 1	The member continues to use substances despite appropriate motivation, peer	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 145:8-21.
	support such as can be provided in an organized sobriety group, and an	Motivation (see Br. § II.G.6; PFF	
	adequate trial of routine outpatient care.	§ X.F)	
[Any] 2	The member's psychosocial functioning has become impaired by moderate-	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 145:8-12, 145:22-146:4.
	severe symptoms of a substance use disorder, and treatment cannot be safely	<u>Drive Toward Lower Levels of Care</u>	
	managed in a less intensive level of care.	(see Br. § II.G.3; PFF § X.C)	
[Any] 3	The member's mood, affect or cognition has deteriorated to the extent that a	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 145:8-12, 146:5-13.
	higher level of care will likely be needed if treatment in an intensive		
	outpatient program is not provided		
[Any] 4	The member's symptoms have deteriorated to the extent that there is a	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 225:19-226:13.
	likelihood of imminent relapse if treatment is not provided in an intensive	<u>Drive Toward Lower Levels of Care</u>	
	outpatient program.	(see Br. § II.G.3; PFF § X.C)	
[All] 3	Co-occurring medical conditions, if any, can be safely managed in an	Co-occurring (see Br. § II.G.2; PFF	<u>Fishman</u> : Tr. 107:20-108:24.
	outpatient setting.	§ X.B)	
[All] 4	Co-occurring mental health conditions, if any can be managed in a dual	Co-occurring (see Br. § II.G.2; PFF	<u>Fishman</u> : Tr. 107:20-108:24; <u>Plakun</u> : Tr.
	diagnosis program, or can be safely managed at this level of care.	§ X.B)	526:14-16.
[All] 5	The member or his/her family/social support system understands and can	Motivation (see Br. § II.G.6; PFF	<u>Fishman</u> : Tr. 146:17-147:9.
	comply with the requirements of an IOP, or the member is likely to	§ X.F)	
	participate in treatment with the structure and supervision afforded by an IOP.		
[All]	Within the first 3 days of treatment, the following should occur: (a) A	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 147:10-12, 147:24-148:2.
6(a)	psychiatrist completes a comprehensive evaluation of the member when the		
	member has been directly admitted from an inpatient setting.		
[All] 8	The provider and, whenever possible, the member collaborate to update the	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 148:3-19.
	treatment plan every 3 to 5 treatment days in response to changes in the	<u>Drive Toward Lower Levels of Care</u>	
	member's condition, or provide compelling evidence that continued treatment	(see Br. § II.G.3; PFF § X.C)	
	in the current level of care is required to prevent acute deterioration or		
	exacerbation of the member's current condition.		

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³ In each year, for admission and continued service, members must have satisfied the Common Criteria. Thus, insofar as the LOCG subsections for each level of care incorporates the Common Criteria, Plaintiffs challenge those as well.

F. Outpatient: Substance Use Disorders (Ex. 1-0046 to -0048)

\P	Criterion	Why Flawed	Testimony
[Any] 2	Lapse has occurred or is imminent, and treatment is needed to	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 148:20-149:16.
	maintain/regain abstinence.		
[All] 3	Co-occurring mental health conditions, if present, are stable and are	Co-occurring (see Br. § II.G.2; PFF	<u>Fishman</u> : Tr. 107:20-108:24.
	unlikely to undermine treatment of the substance use disorder at this level	§ X.B)	
	of care.		
[Consider]	The member refuses further treatment or repeatedly does not adhere with	Motivation (see Br. § II.G.6; PFF	<u>Fishman</u> : Tr. 236:12-237:4, 135:10-136:15.
2	recommended treatment despite motivational support from the provider,	§ X.F);	
	peer support and other community support services. In such cases, the		
	provider explains the risks of discontinuing treatment to the member and, as		
	appropriate, the member's family/social supports, alternative referrals are		
	provided in writing, and the member is provided with instructions for		
	resuming services should the need arise in the future.		

G. Residential Rehabilitation: Substance Use Disorders (Ex. 1-0056 to -0059)

\P	Criterion	Why Flawed	Testimony
Intro	Residential rehabilitation is comprised of acute overnight services	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 281:1-6 (explaining improper
			focus of acuity for residential rehabilitation).
[Any] 1	The member continues to use substances despite appropriate motivation and	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 138:1-16, 140:1-23.
	recent treatment in an intensive outpatient program or partial hospital/day	Motivation (see Br. § II.G.6; PFF	
	treatment program.	§ X.F);	
[Any] 2	The member continues to use substances, and the member's functioning has	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 138:22-139:13, 140:1-23.
	deteriorated to the point that the member cannot be safely treated in a less	Drive Toward Lower Levels of Care	
	restrictive level of care.	(see Br. § II.G.3; PFF § X.C)	
[Any] 3	The member continues to use substances, is at risk of exacerbating a serious	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 138:22-139:20, 140:1-23.
	co-occurring medical condition, and cannot be safely treated in a lower level	Co-occurring (see Br. § II.G.2; PFF	
	of care.	§ X.B); <u>Drive Toward Lower Levels</u>	
		of Care (see Br. § II.G.3; PFF § X.C)	

¶	Criterion	Why Flawed	Testimony
[Any] 4	The member is at risk of developing withdrawal symptoms which cannot be	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 138:22-139:13, 140:1-23.
	safely treated in a lower level of care.	<u>Drive Toward Lower Levels of Care</u>	
		(see Br. § II.G.3; PFF § X.C)	
[Any] 5	Severe impairment in the member's family or social support system has	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 141:20-142:14, 140:1-23.
	heightened the risk that the member will use substances if not in residential		
[rehabilitation.	A	E'alamana Ta 120,22 120,20 140,1 22
[Any] 6	The member is experiencing withdrawal symptoms that do not compromise	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 138:22-139:20, 140:1-23.
	the member's medical status, but are of extreme subjective severity accompanied by the lack of resources or functional social supports to manage	Drive Toward Lower Levels of Care	
	the symptoms.	(see Br. § II.G.3; PFF § X.C)	
[All] 2.a.	Within 48 hours of admission, the following occurs:	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 142:15-143:10; <u>Alam</u> : Tr.
[AII] 2.a.	a. A psychiatrist/addictionologist completes a comprehensive evaluation	Acuity (see Dr. § 11.0.1, 111 § A.A)	1586:19-1587:21 (conceding that residential
	of the member.		treatment does not "require[] a physician to
	of the memoer.		do anything like what – to do what is required
			by the Level of Care Guidelines").
[All] 3	Subsequent psychiatric evaluations and consultations are available 24 hours a	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 142:24-144:23; Alam: Tr.
[]	day. Visits with the treating psychiatrist/addictionologist occur at least 2	=======================================	1586:19-1587:21.
	times per week.		
[All] 4	All relevant general medical services, including assessment and diagnostic,	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 221:23-223:23.
	treatment, and consultative services are available as needed and provided with	Co-occurring (see Br. § II.G.2; PFF	
	an urgency that is commensurate with the member's medical need. Co-	§ X.B)	
	occurring medical conditions can be safely treated in this level of care.		
[All] 5	The treating psychiatrist/addictionologist and, whenever possible, the member	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 142:24-144:23; <u>Alam</u> : 1582:24-
	collaborate to update the treatment plan at least every 5 days in response to	Maintenance of Function (see Br.	1583:9; 1584:1-6; 1584:11-13 (agreeing that
	changes in the member's condition, or provide compelling evidence that	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	"compelling" is not "a medical term" and
	continued treatment in the current level of care is required to prevent acute	Lower Levels of Care (see Br.	does not comply with generally accepted
	deterioration or exacerbation of the member's current condition	§ II.G.3; PFF § X.C)	standards of care).

¶	Criterion	Why Flawed	Testimony
[All] 5.a	a. Treatment in a residential setting is not for the purpose of providing	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 142:24-144:23.
	custodial care, but is for the active treatment of a substance use	Maintenance of Function (see Br.	
	disorder. Active treatment is a clinical process involving 24-hour care	§ II.G.5; PFF § X.E); Drive Toward	
	that includes assessment, diagnosis, intervention, evaluation of care,	Lower Levels of Care (see Br.	
	treatment and planning for discharge and aftercare. Active treatment is	§ II.G.3; PFF § X.C);	
	indicated by services that are all of the following:	Custodial/Improvement (see Br.	
	i. Supervised and evaluated by a physician;	§ II.G.8; PFF § X.H)	
	ii. Provided under an individualized treatment plan;		
	iii. Reasonably expected to improve the member's condition or for		
	the purpose of diagnosis;		
	iv. Unable to be provided in a less restrictive setting; and are		
	v. Focused on interventions that are based on generally accepted		
	standards of medical practice and are known to address the		
	critical presenting problem(s), psychosocial issues and		
	stabilize the member's condition to the extent that the member		
	can be safely treated in a lower level of care		

III. 2012 LEVEL OF CARE GUIDELINES (EX. 2)

A. Common Criteria (Ex. 2-0006 to -0009 & Ex. 2-0082)

1. Admission Criteria (Ex. 2-0006 to -0009)

¶	Criterion	Why Flawed	Testimony
5	The member's current condition cannot be effectively and safely treated in a	Drive Toward Lower Levels of Care	Fishman: E.g., Tr. 97:10-14 ("[W]hat we
	lower level of care even when the treatment plan is modified, attempts to	(see Br. § II.G.3; PFF § X.C)	want from a level of care placement matching
	enhance the member's motivation have been made, or referrals to community		guideline are decision rules that direct a user
	resources or peer supports have been made.		to place a patient where the treatment will be
			<i>most effective</i> , where the outcomes will be
			best, where their journey of recovery will
			likely be aided in the <i>most successful</i> way.");
			213:6-18 ("what typically drives decisions are
			[what level of care will be] most effective");
			<u>Plakun</u> : <i>E.g.</i> , Tr. 511:25-512:6 ("The more
			important issue is, what's the <i>most effective</i>
			way for this person to get better.").
6	There must be a reasonable expectation that essential and appropriate services	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 218:6-23; Plakun: Tr. 539:14-
	will improve the member's presenting problems within a reasonable period of	Maintenance of Function (see Br.	19, 540:3-6; <u>Niewenhous</u> : Tr. 332:6-334:12
	time. Improvement of the member's condition is indicated by the reduction or	§ II.G.5; PFF § X.E);	(testimony regarding CMS standards).
	control of the acute symptoms that necessitated treatment in a level of care.	Custodial/Improvement (see Br.	
	Improvement in this context is measured by weighing the effectiveness of	§ II.G.8; PFF § X.H)	
	treatment against the evidence that the member's condition will deteriorate if		
	treatment is discontinued in the current level of care. Improvement must also		
	be understood within the framework of the member's broader recovery goals.		
7	The goal of treatment is to improve the member's presenting symptoms to the	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 218:24-219:4; <u>Plakun</u> : Tr.
	point that treatment in the current level of care is no longer required.	Maintenance of Function (see Br.	539:14-17, 19-23.
		§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
		Lower Levels of Care (see Br.	
		§ II.G.3; PFF § X.C)	

\P	Criterion	Why Flawed	Testimony
8	Treatment is not primarily for the purpose of providing respite for the family,	Maintenance of Function (see Br.	Fishman: Tr. 219:5-11.
	increasing the member's social activity, or for addressing antisocial behavior	§ II.G.5; PFF § X.E);	
	or legal problems, but is for the active treatment of a behavioral health	Custodial/Improvement (see Br.	
	condition.	§ II.G.8; PFF § X.H)	
	The treatment plan stems from the member's presenting condition, and	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 219:12-19.
10	clearly documents realistic and measurable treatment goals as well as the		
	treatments that will be used to achieve the goals of treatment		

2. Continued Service Criteria (Ex. 2-0082)

¶	Criterion	Why Flawed	Testimony
5	There continues to be evidence that the member is receiving active treatment,	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 220:6-18; Plakun: Tr. 540:11-
	and there continues to be a reasonable expectation that the member's	Maintenance of Function (see Br.	24.
	condition will improve further. Lack of progress is being addressed by an	§ II.G.5; PFF § X.E);	
	appropriate change in the member's treatment plan, and/or an intervention to	Custodial/Improvement (see Br.	
	engage the member in treatment.	§ II.G.8; PFF § X.H)	
6	The member's current symptoms and/or history provider [sic] evidence that	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 220:19-221:10; <u>Plakun</u> : Tr.
	relapse or a significant deterioration in functioning would be imminent if the	<u>Drive Toward Lower Levels of Care</u>	540:11-14, 541:1-10.
	member was transitioned to a lower level of care or, in the case of outpatient	(see Br. § II.G.3; PFF § X.C)	
	care, was discharged.	Maintenance of Function (see Br.	
		§ II.G.5; PFF § X.E);	
		Custodial/Improvement (see Br.	
		§ II.G.8; PFF § X.H)	

B. Intensive Outpatient Program: Mental Health Conditions (Ex. 2-0020 to -0022)

¶	Criterion	Why Flawed	Testimony
[Any] 1	The member's psychosocial functioning has become impaired by moderate-	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: E.g., Tr. 97:10-14; 213:6-18;
	severe symptoms of a mental health condition, and treatment cannot be	Drive Toward Lower Levels of Care	<u>Plakun</u> : <i>E.g.</i> , Tr. 511:25-512:6.
	adequately managed in a lower level of care.	(see Br. § II.G.3; PFF § X.C)	-

¶	Criterion	Why Flawed	Testimony
[Any] 2	The member's mood, affect or cognition has deteriorated to the extent that a	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 145:8-12, 146:5-13, 225:19-
	higher level of care will likely be needed if intensive outpatient treatment is		226:8.
	not provided.		
[All] 3	Co-occurring substance use disorders, if present, can be treated in a dual	Co-occurring (see Br. § II.G.2; PFF	<u>Fishman</u> : Tr. 221:23-223:23; <u>Plakun</u> : Tr.
	diagnosis program, or can be safely managed at this level of care.	§ X.B)	526:14-16, 525:11-529:14.
[All] 4	The member and/or his/her family/social support system understands and can	Motivation (see Br. § II.G.6; PFF	<u>Fishman</u> : Tr. 146:17-147:9.
	comply with the requirements of an IOP, or the member is likely to	§ X.F)	
	participate in treatment with the structure and supervision afforded by an IOP.		
[All] 7	The provider and, whenever possible, the member collaborate to update the	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 575:8-10, 14-21.
	treatment plan every 3 to 5 treatment days in response to changes in the	Drive Toward Lower Levels of Care	
	member's condition, or provide compelling evidence that continued treatment	(see Br. § II.G.3; PFF § X.C)	
	in the current level of care is required to prevent acute deterioration or		
	exacerbation of the member's current condition.		

C. Outpatient: Mental Health Conditions (Ex. 2-0023 to -0024)

\P	Criterion	Why Flawed	Testimony
[All] 3	Co-occurring substance use disorders, if present, are stable and are unlikely	Co-occurring (see Br. § II.G.2; PFF	Fishman: Tr. 221:23-223:23; Plakun: Tr.
	to undermine treatment of the mental health condition at this level of care.	§ X.B)	526:14-16, 525:11-529:14.
[Consider]	The member refuses further treatment or repeatedly does not adhere with	Motivation (see Br. § II.G.6; PFF	Fishman: Tr. 236:12-237:4, 135:10-136:15.
2	recommended treatment despite attempts to enhance the member's	§ X.F);	
	engagement in treatment, peer support and other community support		
	services. In such cases, the provider explains the risks of discontinuing		
	treatment to the member and, as appropriate, the member's family/social		
	supports; alternative referrals are offered; and the member is provided with		
	instructions for resuming services should the need arise in the future.		

D. Residential Treatment Center: Mental Health Conditions (Ex. 2-0028 to -0031)

¶_	Criterion	Why Flawed	Testimony
[Any] 1	The member is experiencing a disturbance in mood, affect or cognition	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 145:8-12, 146:5-13, 225:19-
	resulting in behavior that cannot be safely managed in a less restrictive	Drive Toward Lower Levels of Care	226:8; <u>Plakun</u> : Tr. 526:8-16, 528:15-19
	setting.	(see Br. § II.G.3; PFF § X.C)	
[Any] 2	There is an imminent risk that severe, multiple and/or complex psychosocial	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 236:2-10, 272:9-19; Plakun: Tr.
	stressors will produce significant enough distress or impairment in	<u>Drive Toward Lower Levels of Care</u>	540:11-14, 541:1-10.
	psychological, social, occupational/educational, or other important areas of	(see Br. § II.G.3; PFF § X.C)	
	functioning to undermine treatment in a lower level of care.		
[Any] 3	The member has a co-occurring medical disorder or substance use disorder	Co-occurring (see Br. § II.G.2; PFF	<u>Fishman</u> : Tr. 221:23-223:23; <u>Plakun</u> : Tr.
	which complicates treatment of the presenting mental health condition to the	§ X.B)	526:14-16, 525:11-529:14.
	extent that treatment in a Residential Treatment Center is necessary.		
[All]	Within 48 hours of admission, the following occurs:	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 142:15-143:10; <u>Alam</u> : Tr.
2(a)	a. A psychiatrist completes a comprehensive evaluation of the member.		1586:19-1587:21 (conceding that residential
			treatment does not "require[] a physician to
			do anything like what – to do what is required
			by the Level of Care Guidelines").
[All] 3	Subsequent psychiatric evaluations and consultations are available 24 hours a	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 142:15-143:10; <u>Alam</u> : Tr.
	day. Visits with the treating psychiatrist occur at least 2 times per week.		1586:19-1587:21 (conceding that residential
			treatment does not "require[] a physician to
			do anything like what – to do what is required
			by the Level of Care Guidelines").
[All] 4	All relevant general medical services, including assessment and diagnostic,	Co-occurring (see Br. § II.G.2; PFF	<u>Fishman</u> : Tr. 221:23-223:23; Plakun: Tr.
	treatment, and consultative services are available as needed and provided with	§ X.B)	518:4-8, 526:8-16, 528:15-19.
	an urgency commensurate with the member's medical need. Co-occurring		
	medical conditions can be safely treated in this level of care.		

\P	Criterion	Why Flawed	Testimony
[All] 5	The provider and, whenever possible, the member collaborate to update the	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 576:1-15, 18-21; Alam: Tr.
	treatment plan at least weekly in response to changes in the member's	Drive Toward Lower Levels of Care	1616:11-25 (identifying "compelling" as not
	condition, or provide compelling evidence that continued treatment in the	(see Br. § II.G.3; PFF § X.C);	consistent with generally accepted standards
	current level of care is required to prevent acute deterioration or exacerbation	Maintenance of Function (see Br.	of care); <u>Triana</u> : Tr. 1738:23-1739:13,
	of the member's current condition.	§ II.G.5; PFF § X.E);	1739:19-1740:23 (agreeing that b.iv) and v)
		Custodial/Improvement (see Br.	are not in the CMS definition of "active
		§ II.G.8; PFF § X.H)	treatment").
[All] 5.a	a. Treatment in a residential setting is not for the purpose of providing	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 576:1-22.
	custodial care. Custodial care in a residential setting is the	Maintenance of Function (see Br.	
	implementation of clinical or non-clinical services that do not seek to	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
	cure, or which are provided during periods when the member's mental	Lower Levels of Care (see Br.	
	health condition is not changing, or does not require trained clinical	§ II.G.3; PFF § X.C);	
	personnel to safely deliver services. Examples of custodial care	Custodial/Improvement (see Br.	
	include respite services, daily living skills instruction, days awaiting	§ II.G.8; PFF § X.H)	
	placement, activities that are social and recreational in nature, and		
	interventions that are solely to prevent runaway/truancy or legal		
	problems. Custodial care is characterized by the following:		
	i) The member's presenting signs and symptoms have been		
	stabilized, resolved, or a baseline level of functioning has		
	been achieved;		
	ii) The member is not responding to treatment or otherwise is		
	not improving;		
	iii) The intensity of active treatment provided in a residential		
	setting is no longer required or services can be safely		
	provided in a less intensive setting.		

¶	Criterion	Why Flawed	Testimony
[All] 5.b	b. Treatment in a residential setting is for the active treatment of a	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 576:1-22.
	mental health condition. Active treatment is a clinical process	Maintenance of Function (see Br.	
	involving 24-hour care that includes assessment, diagnosis,	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
	intervention, evaluation of care, treatment and planning for discharge	Lower Levels of Care (see Br.	
	and aftercare. Active treatment is indicated by services that are all of	§ II.G.3; PFF § X.C);	
	the following:	<u>Custodial/Improvement</u> (see Br.	
	i) Supervised and evaluated by a physician;	§ II.G.8; PFF § X.H)	
	ii) Provided under an individualized treatment plan;		
	iii) Reasonably expected to improve the member's condition or		
	for the purpose of diagnosis;		
	iv) Unable to be provided in a less restrictive setting; and are		
	v) Focused on interventions that are based on generally		
	accepted standards of medical practice and are known to		
	address the critical presenting problem(s), psychosocial		
	issues and stabilized the member's condition to the extent		
	that the member can be safely treated in a lower level of care.		

E. Intensive Outpatient Program: Substance Use Disorders (Ex. 2-0047 to -0050)

\P	Criterion	Why Flawed	Testimony
[Any] 1	The member's psychosocial functioning has become impaired by moderate-	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 225:19-226:3.
	severe symptoms of a substance use disorder, and treatment cannot be safely	Drive Toward Lower Levels of Care	
	managed in a less intensive level of care; or	(see Br. § II.G.3; PFF § X.C)	
[Any] 2	The member's mood, affect or cognition has deteriorated to the extent that a	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 225:19-226:8.
	higher level of care will likely be needed if treatment in an intensive		
	outpatient program is not provided; or		
[Any] 3	The member's symptoms have deteriorated to the extent that there is a	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 225:19-226:13.
	likelihood of imminent relapse if treatment is not provided in an intensive	<u>Drive Toward Lower Levels of Care</u>	
	outpatient program; or	(see Br. § II.G.3; PFF § X.C)	
[Any] 5	The member has a non-supportive or unstable living situation creating an	Motivation (see Br. § II.G.6; PFF	<u>Fishman</u> : Tr. 225:19-226:26.
	environment in which the member is unlikely to remain sober without the	§ X.F)	
	structure and support of the intensive outpatient program.		

¶	Criterion	Why Flawed	Testimony
[All] 3	Co-occurring medical conditions, if any, can be safely managed in an	Co-occurring (see Br. § II.G.2; PFF	<u>Fishman</u> : Tr. 225:19-24, 228:2-14.
	outpatient setting.	§ X.B)	
[All] 4	Co-occurring mental health conditions, if any can be managed in a dual	Co-occurring (see Br. § II.G.2; PFF	<u>Fishman</u> : Tr. 225:19-24, 228:2-14.
	diagnosis program, or can be safely managed at this level of care.	§ X.B)	
[All] 8	The provider and, whenever possible, the member collaborate to update the	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 225:19-24, 229:17-230:16.
	treatment plan every 3 to 5 treatment days in response to changes in the	Drive Toward Lower Levels of Care	
	member's condition, or provide compelling evidence that continued treatment	(see Br. § II.G.3; PFF § X.C)	
	in the current level of care is required to prevent acute deterioration or		
	exacerbation of the member's current condition.		

F. Outpatient: Substance Use Disorders (Ex. 2-0051 to -0053)

\P	Criterion	Why Flawed	Testimony
[Any] 2	Lapse has occurred or is imminent, and treatment is needed to	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 230:19-231:5.
	maintain/regain abstinence.		
[All] 3	Co-occurring mental health conditions, if present, are stable and are	Co-occurring (see Br. § II.G.2; PFF	Fishman: Tr. 107:20-108:24.
	unlikely to undermine treatment of the substance use disorder at this level	§ X.B)	
	of care.		
[Consider]	The member refuses further treatment or repeatedly does not adhere with	Motivation (see Br. § II.G.6; PFF	Fishman: Tr. 236:12-237:4, 135:10-136:15.
2	recommended treatment despite attempts to enhance the member's	§ X.F)	
	engagement in treatment, and/or peer support and other community support		
	services. In such cases, the provider explains the risks of discontinuing		
	treatment to the member and, as appropriate, the member's family/social		
	supports, alternative referrals are provided in writing, and the member is		
	provided with instructions for resuming services should the need arise in the		
	future.		

G. Residential Rehabilitation: Substance Use Disorders (Ex. 2-0062 to -0065)

¶	Criterion	Why Flawed	Testimony
Preamble	Residential rehabilitation is comprised of acute overnight services	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 281:1-6 (explaining improper
			focus of acuity for residential rehabilitation)

\P	Criterion	Why Flawed	Testimony
[Any] 1	The member continues to use alcohol or drugs, and the member's	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 221:23-222:16.
	functioning has deteriorated to the point that the member cannot be safely	Drive Toward Lower Levels of Care	
	treated in a less restrictive level of care; or	(see Br. § II.G.3; PFF § X.C)	
[Any] 2	The member continues to use alcohol or drugs, is at risk of exacerbating a	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 221:23-222:19.
	serious co-occurring medical condition, and cannot be safely treated in a	Co-occurring (see Br. § II.G.2; PFF	
	lower level of care; or	§ X.B); <u>Drive Toward Lower Levels</u>	
		of Care (see Br. § II.G.3; PFF § X.C)	
[Any] 3	There is a high risk of harm to self or others due to continued and severe	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 221:23-223:01.
	alcohol or drug use which prohibits treatment from safely occurring in a	<u>Drive Toward Lower Levels of Care</u>	
	less restrictive level of care; or	(see Br. § II.G.3; PFF § X.C)	
[Any] 4	There is a high risk that continued use of alcohol or drugs will exacerbate a	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 221:23-223:03.
	co-occurring medical condition to the extent that treatment in a less	Co-occurring (see Br. § II.G.2; PFF	
	restrictive level of care cannot be safely provided; or	§ X.B); <u>Drive Toward Lower Levels</u>	
		of Care (see Br. § II.G.3; PFF § X.C)	
[Any] 5	There is a high risk of developing severe withdrawal symptoms which	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 221:23-223:05.
	cannot be safely treated in a lower level of care; or	<u>Drive Toward Lower Levels of Care</u>	
		(see Br. § II.G.3; PFF § X.C)	
[Any] 6	The member is experiencing withdrawal symptoms that do not compromise	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 221:23-222:19.
	the member's medical status to the extent that treatment in an inpatient	Drive Toward Lower Levels of Care	
	setting is indicated, but the symptoms are of extreme subjective severity and	(see Br. § II.G.3; PFF § X.C)	
	the member lacks resources or a functional social support system needed to		
5 / 113 6	manage the symptoms in a lower level of care.		
[All] 2.a.	Within 48 hours of admission, the following occurs:	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 221:23-223:11; Alam: Tr.
	a. A psychiatrist/addictionologist completes a comprehensive		1586:19-1587:21 (conceding that residential
	evaluation of the member.		treatment does not "require[] a physician to
			do anything like what – to do what is required
FA113.0		A '. / D GHC1 DEEGYA	by the Level of Care Guidelines").
[All] 3	Subsequent psychiatric evaluations and consultations are available 24 hours	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 221:23-223:16; Alam: Tr.
	a day. Visits with the treating psychiatrist/addictionologist occur at least 2		1586:19-1587:21 (conceding that residential
	times per week.		treatment does not "require[] a physician to
			do anything like what – to do what is required
			by the Level of Care Guidelines").

\P	Criterion	Why Flawed	Testimony
[All] 4	All relevant general medical services, including assessment and diagnostic,	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 221:23-223:23; Alam: Tr.
	treatment, and consultative services are available as needed and provided	Co-occurring (see Br. § II.G.2; PFF	1586:19-1587:21.
	with an urgency that is commensurate with the member's medical need. Co-	§ X.B)	
	occurring medical conditions can be safely treated in this level of care.		
[All] 5	The treating psychiatrist/addictionologist and, whenever possible, the	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 221:23-224:3; Alam: Tr.
	member collaborate to update the treatment plan at least every 5 days in	Drive Toward Lower Levels of Care	1586:19-1587:21.
	response to changes in the member's condition, or provide compelling	(see Br. § II.G.3; PFF § X.C);	
	evidence that continued treatment in the current level of care is required to	Maintenance of Function (see Br.	
	prevent acute deterioration or exacerbation of the member's current	§ II.G.5; PFF § X.E);	
	condition		
[All] 5.a	a. Treatment in a residential setting is not for the purpose of providing	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 221:23-225:14.
	custodial care. Custodial care in a residential setting involves the	<u>Drive Toward Lower Levels of Care</u>	
	implementation of clinical or non-clinical services that do not seek	(see Br. § II.G.3; PFF § X.C);	
	to cure, or which are provided during periods when the member's	Maintenance of Function (see Br.	
	substance use disorder is not changing, or does not require trained	§ II.G.5; PFF § X.E);	
	clinical personnel to safely deliver services. Examples of custodial	Custodial/Improvement (see Br.	
	care include respite services, daily living skills instruction, days	§ II.G.8; PFF § X.H)	
	awaiting placement, activities that are social and recreational in		
	nature, and interventions that are solely to prevent runaway/truancy		
	or legal problems. Custodial care is characterized by the following:		
	i) The member's presenting signs and symptoms have been		
	stabilized, resolved, or a baseline level of functioning has been		
	achieved;		
	ii) The member is not responding to treatment or otherwise is not		
	improving;		
	iii) The intensity of active treatment provided in a residential		
	setting is no longer required or services can be safely provided		
	in a less intensive setting.		

\P	Criterion	Why Flawed	Testimony
	b. Treatment in a residential setting is for the active treatment of a	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 223:24-225:14.
	substance use disorder. Active treatment is a clinical process	<u>Drive Toward Lower Levels of Care</u>	
	involving 24-hour care that includes assessment, diagnosis,	(see Br. § II.G.3; PFF § X.C);	
	intervention, evaluation of care, treatment and planning for	Maintenance of Function (see Br.	
	discharge and aftercare. Active treatment is indicated by services	§ II.G.5; PFF § X.E);	
	that are all of the following:	Custodial/Improvement (see Br.	
	i) Supervised and evaluated by a physician;	§ II.G.8; PFF § X.H)	
	ii) Provided under an individualized treatment plan;		
	iii) Reasonably expected to improve the member's condition or for		
	the purpose of diagnosis;		
	iv) Unable to be provided in a less restrictive setting; and are		
	focused on interventions that are based on generally accepted		
	standards of medical practice and are known to address the		
	critical presenting problem(s), psychosocial issues and stabilize		
	the member's condition to the extent that the member can be		
	safely treated in a lower level of care.		

IV. 2013 LEVEL OF CARE GUIDELINES (EX. 3)

A. Common Criteria (Ex. 3-0007 to -0011 & Ex. 3-0089)

1. Admission Criteria (Ex. 3-0007 to -0011)

\P	Criterion	Why Flawed	Testimony
6	The member's current condition cannot be effectively and safely treated in a	Drive Toward Lower Levels of Care	Fishman: E.g., Tr. 97:10-14; 213:6-18;
	lower level of care even when the treatment plan is modified, attempts to	(see Br. § II.G.3; PFF § X.C)	Plakun: E.g., Tr. 511:25-512:6, 526:2-527:1.
	enhance the member's engagement in treatment have been made; or referrals		
	to community resources or peer supports have been made.		

\P	Criterion	Why Flawed	Testimony
7	There must be a reasonable expectation that essential and appropriate services	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 231:14-232:2; <u>Plakun</u> : Tr.
	will improve the member's presenting problems within a reasonable period of	Maintenance of Function (see Br.	542:3-13.
	time. Improvement of the member's condition is indicated by the reduction or	§ II.G.5; PFF § X.E);	
	control of the acute symptoms that necessitated treatment in a level of care.	Custodial/Improvement (see Br.	
	Improvement in this context is measured by weighing the effectiveness of	§ II.G.8; PFF § X.H);	
	treatment against the evidence that the member's condition will deteriorate if		
	treatment is discontinued in the current level of care. Improvement must also		
	be understood within the framework of the member's broader		
	recovery/resiliency goals.		
8	The goal of treatment is to improve the member's presenting symptoms to the	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 232:3-7; <u>Plakun</u> : Tr. 542:3-7,
	point that treatment in the current level of care is no longer required.	Maintenance of Function (see Br.	14-20.
		§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
		Lower Levels of Care (see Br.	
		§ II.G.3; PFF § X.C)	
	Treatment is not primarily for the purpose of providing respite for the family,	Custodial/Improvement (see Br.	<u>Fishman</u> : Tr. 232:8-10.
9	increasing the member's social activity, or for addressing antisocial behavior	§ II.G.8; PFF § X.H); Maintenance of	
	or legal problems, but is for the active treatment of a behavioral health	Function (see Br. § II.G.5; PFF	
	condition.	§ X.E)	
	The provider and, whenever possible, the member develop a treatment plan	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 219:12-19.
10	that stems from the member's presenting condition, and includes		
10	outcomes that are directly related to the reason service in the proposed		
	level of care is being requested.		

2. Continued Service Criteria (Ex. 3-0089)

\P	Criterion	Why Flawed	Testimony
5	There continues to be evidence that the member is receiving active treatment,	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 232:24-233:11.
	and there continues to be a reasonable expectation that the member's	Maintenance of Function (see Br.	
	condition will improve further. Lack of progress is being addressed by an	§ II.G.5; PFF § X.E);	
	appropriate change in the member's treatment plan, and/or an intervention to	Custodial/Improvement (see Br.	
	engage the member in treatment.	§ II.G.8; PFF § X.H);	

\P	Criterion	Why Flawed	Testimony
6	The member's current symptoms and/or history provide evidence that relapse	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 543:3-16.
	or a significant deterioration in functioning would be imminent if the member	Drive Toward Lower Levels of Care	
	was transitioned to a lower level of care or, in the case of outpatient care, was	(see Br. § II.G.3; PFF § X.C);	
	discharged.		

B. Intensive Outpatient Program: Mental Health Conditions (Ex. 3-0022 to -0025)

¶	Criterion	Why Flawed	Testimony
[Any] 1	Moderate symptoms of a mental health condition cannot be managed in a	Drive Toward Lower Levels of Care	Fishman: E.g., Tr. 97:10-14; 213:6-18;
	less intensive level of care	(see Br. § II.G.3; PFF § X.C);	Plakun: E.g., Tr. 511:25-512:6, 526:2-527:1
[All] 2	The member's co-occurring medical, mental health or substance use	Co-occurring (see Br. § II.G.2; PFF	<u>Plakun</u> : Tr. 525:11-529:14.
	conditions can be safely managed in an intensive outpatient program.	§ X.B)	

C. Outpatient: Mental Health Conditions (Ex. 3-0026 to -0028)

\P	Criterion	Why Flawed	Testimony
[Consider]	The member refuses further treatment or repeatedly does not adhere with	Motivation (see Br. § II.G.6; PFF	Fishman: Tr. 236:12-237:4, 135:10-136:15.
2	recommended treatment despite attempts to enhance the member's	§ X.F)	
	engagement in treatment, peer support and other community support		
	services. In such cases, the provider explains the risks of discontinuing		
	treatment to the member and, as appropriate, the member's family/social		
	supports; alternative referrals are offered; and the member is provided with		
	instructions for resuming services should the need arise in the future.		
[All] 3	Co-occurring substance use disorders, if present, are stable and are unlikely	Co-occurring (see Br. § II.G.2; PFF	Fishman: Tr. 221:23-223:23; Plakun: Tr.
	to undermine treatment of the mental health condition at this level of care.	§ X.B)	526:14-16, 525:11-529:14.

D. Residential Treatment Center: Mental Health Conditions (Ex. 3-0033 to -0036)

\P	Criterion	Why Flawed	Testimony
[Any] 1	The member is experiencing a disturbance in mood, affect, or cognition	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: E.g., Tr. 97:10-14; 213:6-18;
	resulting in behavior that cannot be safely managed in a less restrictive	Drive Toward Lower Levels of Care	<u>Plakun</u> : <i>E.g.</i> , Tr. 511:25-512:6, 526:2-527:1.
	setting.	(see Br. § II.G.3; PFF § X.C)	

\P	Criterion	Why Flawed	Testimony
[Any 2]	There is an imminent risk that severe, multiple, and/or complex psychosocial	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : <i>E.g.</i> , Tr. 97:10-14; 213:6-18;
	stressors will produce significant enough distress or impairment in	<u>Drive Toward Lower Levels of Care</u>	<u>Plakun</u> : <i>E.g.</i> , Tr. 511:25-512:6.
	psychological, social, occupational/educational, or other important areas of	(see Br. § II.G.3; PFF § X.C);	
	functioning to undermine treatment in a lower level of care.		
[All] 2.a.	Within 48 hours of admission, the following occurs:	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 142:15-143:10; <u>Alam</u> : Tr.
	a. A psychiatrist completes a comprehensive evaluation of the member.		1586:19-1587:21 (conceding that residential
			treatment does not "require[] a physician to
			do anything like what – to do what is required
			by the Level of Care Guidelines").
[All] 3	Subsequent psychiatric evaluations and consultations are available 24 hours a	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 142:15-143:10; <u>Alam</u> : Tr.
	day. Visits with the treating psychiatrist occur at least 2 times per week.		1586:19-1587:21.
[All] 4	All relevant general medical services, including assessment and diagnostic,	Co-occurring (see Br. § II.G.2; PFF	<u>Fishman</u> : Tr. 221:23-223:23.
	treatment, and consultative services are available as needed and provided with	§ X.B)	
	an urgency commensurate with the member's medical need. Co-occurring		
	medical conditions can be safely treated in this level of care.		
[All] 5	Treatment in a Residential Treatment Center is not for the purpose of	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 577:9-578:4.
	providing custodial care. Custodial care in a Residential Treatment Center is	Drive Toward Lower Levels of Care	
	the implementation of clinical or non-clinical services that do not seek to	(see Br. § II.G.3; PFF § X.C);	
	cure, or which are provided during periods when the member's mental health	Maintenance of Function (see Br.	
	condition is not changing, or does not require trained clinical personnel to	§ II.G.5; PFF § X.E);	
	safely deliver services. Examples of custodial care include respite services,	Custodial/Improvement (see Br.	
	daily living skills instruction; days awaiting placement, activities that are	§ II.G.8; PFF § X.H)	
	social and recreational in nature, and interventions that are solely to prevent		
	runaway/truancy or legal problems. Custodial care is characterized by the		
	following:		
	a. The member's presenting signs and symptoms have been stabilized, resolved, or a baseline level of functioning has been achieved;		
	b. The member is not responding to treatment or otherwise is not improving;		
	c. The intensity of active treatment provided in a residential setting is no		
	longer required or services can be safely provided in a less intensive setting.		
	beams.		

¶	Criterion	Why Flawed	Testimony
[All] 6	Treatment in a Residential Treatment Center is for the active treatment of a	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 577:9-21.
	mental health condition. Active treatment is a clinical process involving 24-	<u>Drive Toward Lower Levels of Care</u>	
	hour care that includes assessment, diagnosis, intervention, evaluation of care,	(see Br. § II.G.3; PFF § X.C);	
	treatment and planning for discharge and aftercare. Active treatment is	Maintenance of Function (see Br.	
	indicated by services that are all of the following:	§ II.G.5; PFF § X.E);	
	a. Supervised and evaluated by a physician;	Custodial/Improvement (see Br.	
	b. Provided under an individualized treatment plan;	§ II.G.8; PFF § X.H)	
	c. Reasonably expected to improve the member's condition or for the		
	purpose of diagnosis;		
	d. Unable to be provided in a less restrictive setting; and are		
	e. Focused on interventions that are based on generally accepted standards		
	of medical practice and are known to address the critical presenting		
	problem(s), psychosocial issues and stabilize the member's condition to		
	the extent that the member can be safely treated in a lower level of care.		

E. Intensive Outpatient Program: Substance Use Disorders (Ex. 3-0052 to -0055)

\P	Criterion	Why Flawed	Testimony
[Any] 1	Moderate symptoms of a mental health condition cannot be managed in a less	Drive Toward Lower Levels of Care	Fishman: E.g., Tr. 97:10-14; 213:6-18;
	intensive level of care	(see Br. § II.G.3; PFF § X.C);	<u>Plakun</u> : <i>E.g.</i> , Tr. 511:25-512:6, 526:2-527:1.
[All] 3	The member's co-occurring medical, mental health or substance use	Co-occurring (see Br. § II.G.2; PFF	<u>Fishman</u> : Tr. Tr. 225:19-24, 228:2-14.
	conditions can be safely managed in an intensive outpatient program.	§ X.B)	
[All] 4	The member or his/her family/social support system understands and can	Motivation (see Br. § II.G.6; PFF	<u>Fishman</u> : Tr. 235:8-14.
	comply with the requirements of an IOP, or the member is likely to	§ X.F)	
	participate in treatment with the structure and supervision afforded by an IOP.		
[All] 5.a.	A psychiatrist or addictionologist completes a comprehensive evaluation of	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 235:15-19.
	the member when the member has been directly admitted from an inpatient		
	setting.		
[All] 7.a.	A psychiatrist or addictionologist continues to see the member at least weekly	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 235:20-25.
	when the member has been directly admitted from an inpatient setting.		

F. Outpatient: Substance Use Disorders (Ex. 3-0056 to -0058)

¶	Criterion	Why Flawed	Testimony
[Any] 2	Lapse has occurred or is imminent and treatment is needed to	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 236:2-10.
	maintain/regain abstinence.		
[Consider] 2	The member refuses further treatment or repeatedly does not adhere with	Motivation (see Br. § II.G.6; PFF	Fishman: Tr. 236:12-237:4, 135:10-136:15.
	recommended treatment despite attempts to enhance the member's	§ X.F)	
	engagement in treatment, and/or peer support and other community		
	support services. In such cases, the provider explains the risks of		
	discontinuing treatment to the member and, as appropriate, the member's		
	family/social supports, alternative referrals are provided in writing, and		
	the member is provided with instructions for resuming services should the		
	need arise in the future.		

G. Residential Rehabilitation: Substance Use Disorders (Ex. 3-0067 to -0070)

\P	Criterion	Why Flawed	Testimony
Preamble	Residential rehabilitation is comprised of acute overnight services	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 281:1-6 (explaining improper
			focus of acuity for residential rehabilitation)
[Any] 1	The member continues to use alcohol or drugs, and the member's	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 233:13-20.
	functioning has deteriorated to the point that the member cannot be safely	<u>Drive Toward Lower Levels of Care</u>	
	treated in a less restrictive level of care.	(see Br. § II.G.3; PFF § X.C)	
[Any] 2	The member continues to use alcohol or drugs, is at risk of exacerbating a	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 233:13-20.
	serious co-occurring medical condition, and cannot be safely treated in a	Co-occurring (see Br. § II.G.2; PFF	
	lower level of care.	§ X.B); <u>Drive Toward Lower Levels</u>	
		of Care (see Br. § II.G.3; PFF § X.C)	
[Any] 3	There is a high risk of harm to self or others due to continued and severe	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 233:13-20.
	alcohol or drug use which prohibits treatment from safely occurring in a less	Drive Toward Lower Levels of Care	
	restrictive level of care.	(see Br. § II.G.3; PFF § X.C)	
[Any] 4	There is a high risk that continued use of alcohol or drugs will exacerbate a	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 233:13-23.
	co-occurring medical condition to the extent that treatment in a less	Co-occurring (see Br. § II.G.2; PFF	
	restrictive level of care cannot be safely provided.	§ X.B); <u>Drive Toward Lower Levels</u>	
		of Care (see Br. § II.G.3; PFF § X.C)	

\P	Criterion	Why Flawed	Testimony
[Any] 5	There is a high risk of developing severe withdrawal symptoms which	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 233:13-25.
	cannot be safely treated in a lower level of care.	<u>Drive Toward Lower Levels of Care</u>	
		(see Br. § II.G.3; PFF § X.C)	
[Any] 6	The member is experiencing withdrawal symptoms that do not compromise	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 221:23-222:19.
	the member's medical status to the extent that treatment in Acute Inpatient is	<u>Drive Toward Lower Levels of Care</u>	
	indicated, but the symptoms are of extreme subjective severity and the	(see Br. § II.G.3; PFF § X.C)	
	member lacks resources or a functional social support system needed to		
	manage the symptoms in a lower level of care.		
[All] 2.a.	Within 48 hours of admission, the following occurs:	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 234:1-7; <u>Alam</u> : Tr. 1586:19-
	a. A psychiatrist/addictionologist completes a comprehensive		1587:21 (conceding that residential treatment
	evaluation of the member		does not "require[] a physician to do anything
			like what – to do what is required by the
			Level of Care Guidelines").
[All] 3	Subsequent psychiatric evaluations and consultations are available 24 hours	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 234:1-10; Alam: Tr. 1586:19-
	a day. Visits with the treating psychiatrist/addictionologist occur at least 2		1587:21.
	times per week.		
[All] 4	All relevant general medical services, including assessment and diagnostic,	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 221:23-223:23.
	treatment, and consultative services are available as needed and provided	Co-occurring (see Br. § II.G.2; PFF	
	with an urgency that is commensurate with the member's medical need. Co-	§ X.B)	
	occurring medical conditions can be safely treated in this level of care.		

¶	Criterion	Why Flawed	Testimony
[All] 5	Treatment in Residential Rehabilitation is not for the purpose of providing custodial care. Custodial care in Residential Rehabilitation involves the implementation of clinical or non-clinical services that do not seek to cure, or which are provided during periods when the member's substance use disorder is not changing, or does not require trained clinical personnel to safely deliver services. Examples of custodial care include respite services, daily living skills instruction, days awaiting placement, activities that are social and recreational in nature, and interventions that are solely to prevent runaway/truancy or legal problems. Custodial care is characterized by the following: a. The member's presenting signs and symptoms have been stabilized, resolved, or a baseline level of functioning has been achieved; b. The member is not responding to treatment or otherwise is not improving; c. The intensity of active treatment provided in a residential setting is no longer required or services can be safely provided in a less intensive setting.	Acuity (see Br. § II.G.1; PFF § X.A); Maintenance of Function (see Br. § II.G.5; PFF § X.E); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	Fishman: Tr. 234:11-14.
[All] 6.a.	 6. Treatment in Residential Rehabilitation is for the active treatment of a substance use disorder. Active treatment is a clinical process involving 24-hour care that includes assessment, diagnosis, intervention, evaluation of care, treatment and planning for discharge and aftercare. Active treatment is indicated by services that are all of the following: a. Supervised and evaluated by a physician; b. Provided under an individualized treatment plan; c. Reasonably expected to improve the member's condition or for the purpose of diagnosis; d. Unable to be provided in a less restrictive setting; and are e. Focused on interventions that are based on generally accepted standards of medical practice and are known to address the critical presenting problem(s), psychosocial issues and stabilize the member's condition to the extent that the member can be safely treated in a lower level of care. 	Acuity (see Br. § II.G.1; PFF § X.A); Maintenance of Function (see Br. § II.G.5; PFF § X.E); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	Fishman: Tr. 234:25-235:3.

V. <u>2014 LEVEL OF CARE GUIDELINES (EX. 4)</u>

A. Common Criteria (Ex. 4-0007 to -0010)

1. Admission Criteria (Ex. 4-0007 to -0010, first column under "Level of Care Criteria")

┫	Criterion	Why Flawed	Testimony
2nd	The member's current condition cannot be safely, efficiently and effectively	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 250:8-251:7; Plakun: Tr.
black	assessed and/or treated in a less intensive setting due to acute changes in the	Drive Toward Lower Levels of Care	544:12-15, 544:21-545:5; Allchin: Tr.
bullet	member's signs and symptoms and/or psychosocial and environmental factors	(see Br. § II.G.3; PFF § X.C)	1389:1-1390:14.
(page 4-	(i.e., the "why now" factors leading to admission).		
0007)			
6th	There is a reasonable expectation that services will improve the member's	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 250:8-15, 251:8-24, 252:6-
black	presenting problems within a reasonable period of time.	Maintenance of Function (see Br.	253:1; Plakun: Tr. 544:12-15, 545:9-13,
bullet	o Improvement of the member's condition is indicated by the reduction	§ II.G.5; PFF § X.E);	545:21-23.
and sub-	or control of the acute signs and symptoms that necessitated treatment	Custodial/Improvement (see Br.	
bullets	in a level of care.	§ II.G.8; PFF § X.H)	
(page 4-	 Improvement in this context is measured by weighing the 		
0009 to -	effectiveness of treatment against evidence that the member's signs		
0010)	and symptoms will deteriorate if treatment in the current level of care		
	ends. Improvement must also be understood within the broader		
	framework of the member's recovery and resiliency goals.		
7th	Treatment is not primarily for the purpose of providing social, custodial,	Custodial/Improvement (see Br.	Fishman: Tr. 250:8-15; 251:25-252:4; Plakun:
black	recreational, or respite care.	§ II.G.8; PFF § X.H)	Tr. 519:18-22.
bullet			
(page 4-			
0010)			

2. Continued Service Criteria (Ex. 4-0007 to -0009, second column under "Level of Care Criteria")

¶	Criterion	Why Flawed	Testimony
1st black	The admission criteria are still met, and active treatment is being delivered.	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 250:8-15, 253:10-18; Plakun:
bullet and	For treatment to be considered "active treatment" services must be:	Maintenance of Function (see Br.	Tr. 546:1-19.
sub-	 Supervised and evaluated by the admitting provider; 	§ II.G.5; PFF § X.E);	
bullets	 Provided under an individualized treatment plan that is focused on 	<u>Custodial/Improvement</u> (see Br.	
(page 4-	addressing the "why now" factors and makes use of clinical best	§ II.G.8; PFF § X.H)	
0007	practices; and		
to -0008)	o Reasonably expected to stabilize the member's condition and/or the		
	precipitating "why now" factors within a reasonable period of time.		

3. Discharge Criteria (Ex. 4-0007 to -0008, third column under "Level of Care Criteria")

\P	Criterion	Why Flawed	Testimony
Black	The continued stay criteria are no longer met. Examples include:	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 250:8-15, 253:21-254:14;
bullet	o The "why now" factors which led to admission have been addressed	Maintenance of Function (see Br.	<u>Plakun</u> : Tr. 546:22, 547:1-9.
and sub-	to the extent that the member can be safely transitioned to a less	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
bullets	intensive level of care or no longer requires treatment.	Lower Levels of Care (see Br.	
(page 4-		§ II.G.3; PFF § X.C);	
0007 to -	o The member requires care that is primarily social, custodial,	Custodial/Improvement (see Br.	
0008)	recreational, or respite.	§ II.G.8; PFF § X.H); Motivation (see	
		Br. § II.G.6; PFF § X.F)	
	o The member is unwilling or unable to participate in treatment and		
	involuntary treatment or guardianship is not being pursued.		

B. Intensive Outpatient Program: Mental Health Conditions (Ex. 4-0027 to -0033)

\P	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in an Intensive Outpatient Program is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 578:9-579:1, 579:4-15.
	addressing the "why now" factors that precipitated admission (e.g., changes	<u>Drive Toward Lower Levels of Care</u>	
	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that the member's condition can		
	be safely, efficiently and effectively treated in a less intensive level of		
	care		

1. Admission Criteria (Ex. 4-0027 to -0033, first column under "Level of Care Criteria")

\P	Criterion	Why Flawed	Testimony
3rd	Co-occurring behavioral health or physical conditions can be safely managed.	Co-occurring (see Br. § II.G.2; PFF	Fishman: Tr. 190:23-191:13; 107:11-108:5;
black		§ X.B)	108:7-24; Plakun: Tr. 523:19-21; 523:24-
bullet			524:1; 525:8-25; 526:6-527:1; 527:4-528:25;
(page 4-			529:1-14; 529:17-530:2; Niewenhous: Tr.
0028)			1818:9-1820:18 (discussing Ex. 539).

C. Outpatient: Mental Health Conditions (Ex. 4-0034 to -0035)

¶	Criterion	Why Flawed	Testimony
Preamble	Assessment and diagnosis and active behavioral health treatment that are	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 579:19-580:10.
	provided in an ambulatory setting. The course of treatment in Outpatient is	Maintenance of Function (see Br.	
	focused on addressing the "why now" factors that precipitated admission	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
	(e.g., changes in the member's signs and symptoms, psychosocial and	Lower Levels of Care (see Br.	
	environmental factors, or level of functioning) to the point that the "why	§ II.G.3; PFF § X.C)	
	now" factors that precipitated admission no longer require treatment.		

1. Admission Criteria (Ex. 4-0034 to -0035, first column under "Level of Care Criteria")

\P	Criterion	Why Flawed	Testimony
3rd	Co-occurring behavioral health or physical conditions can be safely managed.	Co-occurring (see Br. § II.G.2; PFF	<u>Plakun</u> : Tr. 580:25-581:4.
black		§ X.B)	
bullet			
(page 4-			
0034)			
4th	Acute changes in the member's signs and symptoms and/or psychosocial and	Acuity (see Br. § II.G.1; PFF § X.A)	Plakun: Tr. 579:19-20, 580:13-24.
black	environmental factors (i.e., the "why now" factors leading to admission) have		
bullet	occurred, and the member's current condition can be safely, efficiently and		
(page 4-	effectively assessed and/or treated in this setting.		
0035)			

D. Residential Treatment Center: Mental Health Conditions (Ex. 4-0043 to -0045)

¶	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in a Residential Treatment Center is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 581:11-22.
	addressing the "why now" factors that precipitated admission (e.g., changes	<u>Drive Toward Lower Levels of Care</u>	
	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that the member's condition can		
	be safely, efficiently and effectively treated in a less intensive level of care.		

1. Admission Criteria (Ex. 4-0043 to -0045, first column under "Level of Care Criteria")

¶	Criterion	Why Flawed	Testimony
3rd	Co-occurring behavioral health or physical conditions can be safely managed.	Co-occurring (see Br. § II.G.2; PFF	<u>Plakun</u> : Tr. 581:11-12, 581:24-25, 582:3-5,
black		§ X.B)	582:11-13.
bullet			
(page 4-			
0043)			

\P	Criterion	Why Flawed	Testimony
4th	The "why now" factors leading to admission cannot be safely, efficiently or	Acuity (see Br. § II.G.1; PFF § X.A);	Plakun: Tr. 581:11-12, 581:24-25, 582:7-13.
black	effectively assessed and/or treated in a less intensive setting due to acute	Maintenance of Function (see Br.	
bullet	changes in the member's signs and symptoms and/or psychosocial and	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
and sub-	environmental factors. Examples include:	Lower Levels of Care (see Br.	
bullets	Acute impairment of behavior or cognition that interferes with	§ II.G.3; PFF § X.C)	
(page 4-	activities of daily living to the extent that the welfare of the member		
0044	or others is endangered.		
	Psychosocial and environmental problems that are likely to threaten		
	the member's safety or undermine engagement in a less intensive level		
	of care without the intensity of services offered in this level of care.		

2. <u>Continued Service Criteria (Ex. 4-0043, second column under "Level of Care Criteria")</u>

¶	Criterion	Why Flawed	Testimony
Language after "AND"	 Treatment is not primarily for the purpose of providing custodial care. Custodial care involves services that don't seek to cure, are provided when the member's condition is unchanging, are not required to maintain stabilization, or don't have to be delivered by trained clinical personnel. 	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	Fishman: Tr. 250:8-15; 251:25-252:4; Plakun: Tr. 581:11-12, 581:24-25, 582:19-21.

3. <u>Discharge Criteria (Ex. 4-0043, third column under "Level of Care Criteria")</u>

¶	Criterion	Why Flawed	Testimony
Language after "AND"	Care is custodial. Indications include: • The member's signs and symptoms have been stabilized, resolved, or a baseline level of functioning has been achieved;	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	Fishman: Tr. 250:8-15; 251:25-252:4; Plakun: Tr. 581:11-12, 581:24-25, 582:19-583:7.
	 The member's condition is not improving; or The intensity of active treatment in Inpatient is no longer required. 		

E. Intensive Outpatient Program: Substance-Related Disorders (Ex. 4-0059 to -0065)

¶	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in an Intensive Outpatient Program is focused on	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 254:15-24.
	addressing the "why now" factors that precipitated admission (e.g., changes	<u>Drive Toward Lower Levels of Care</u>	
	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that the member's condition can		
	be safely, efficiently and effectively treated in a less intensive level of		
	care		

1. Admission Criteria (Ex. 4-0059 to -0065, first column under "Level of Care Criteria")

\P	Criterion	Why Flawed	Testimony
3rd	Co-occurring behavioral health or physical conditions can be safely managed.	Co-occurring (see Br. § II.G.2; PFF	Fishman: Tr. 254:15-255:10.
black		§ X.B)	
bullet			
(page 4-			
0060)			

F. Outpatient: Substance-Related Disorders (Ex. 4-0066 to -0067)

\P	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in Outpatient is focused on addressing the "why	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 255:16-21.
	now" factors that precipitated admission (e.g., changes in the member's signs	Maintenance of Function (see Br.	
	and symptoms, psychosocial and environmental factors, or level of	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
	functioning) to the point that the "why now" factors that precipitated	Lower Levels of Care (see Br.	
	admission no longer require treatment.	§ II.G.3; PFF § X.C)	

1. Admission Criteria (Ex. 4-0066 to -0067, first column under "Level of Care Criteria")

¶	Criterion	Why Flawed	Testimony
3rd	Co-occurring behavioral health or physical conditions can be safely managed.	Co-occurring (see Br. § II.G.2; PFF	Fishman: Tr. 190:23-191:13; 107:11-108:5;
black		§ X.B)	108:7-24; <u>Plakun</u> : Tr. 523:19-21; 523:24-
bullet			524:1; 525:8-25; 526:6-527:1; 527:4-528:25;
(page 4-			529:1-14; 529:17-530:2; <u>Niewenhous</u> : Tr.
0066)			1818:9-1820:18 (discussing Ex. 539).
5th	Acute changes in the member's signs and symptoms and/or psychosocial and	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 255:16-17, 255:22-256:05.
black	environmental factors (i.e., the "why now" factors leading to admission) have	Maintenance of Function (see Br.	
bullet	occurred, and the member's current condition can be safely, efficiently and	§ II.G.5; PFF § X.E)	
(page 4-	effectively assessed and/or treated in this setting.		
0067)			

G. Residential Rehabilitation: Substance-Related Disorders (Ex. 4-0077 to -0080)

\P	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in Residential Rehabilitation is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 256:9-18.
	addressing the "why now" factors that precipitated admission (e.g., changes	Drive Toward Lower Levels of Care	
	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that rehabilitation can be safely,		
	efficiently and effectively continued in a less intensive level of care.		

1. Admission Criteria (Ex. 4-0077 to -0080, first column under "Level of Care Criteria")

\P	Criterion	Why Flawed	Testimony
3rd	The "why now" factors leading to admission suggest that physical	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 255:16-17, 255:22-256:05;
black	complications, if present, can be safely managed.	Co-occurring (see Br. § II.G.2; PFF	Alam: Tr. 1611:6-1612:1 (conceding that
bullet		§ X.B)	"this purposefully excludes the notion of
(page 4-			effective care for physical complications if
0077)			present").

\P	Criterion	Why Flawed	Testimony
4th	The "why now" factors leading to admission and/or the member's history of	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 256:9-22.
black	response to treatment suggest that there is imminent or current risk of relapse	Maintenance of Function (see Br.	
bullet	which cannot be safely, efficiently and effectively managed in a less intensive	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
(page 4-	level of care. Examples include:	Lower Levels of Care (see Br.	
0078)	A co-occurring mental health condition is stabilizing but the	§ II.G.3; PFF § X.C); Co-occurring	
	remaining signs and symptoms are likely to undermine treatment in a	(see Br. § II.G.2; PFF § X.B)	
	less intensive setting;		
	The member is in immediate danger of relapse, and the history or		
	treatment suggest that the structure and support provided in this level		
	will be needed to control the recurrence.		
5 th black	The "why now" factors leading to admission cannot be safely, efficiently or	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 256:9-11, 258:5-10.
bullet	effectively assessed and/or treated in a less intensive setting due to acute	Drive Toward Lower Levels of Care	
and sub-	changes in the member's signs and symptoms and/or psychosocial and	(see Br. § II.G.3; PFF § X.C)	
bullets	environmental factors. Examples include:		
(page 4-	Acute impairment of behavior or cognition that interferes with		
0079 to -	activities of daily living to the extent that the member's condition		
0080)	cannot be safely, efficiently and effectively managed in a less		
	intensive level of care;		
	 Psychosocial and environmental problems that threaten the member's 		
	safety or undermines engagement in a less intensive level of care.		

2. <u>Continued Service Criteria (Ex. 4-0077, second column under "Level of Care Criteria")</u>

\P	Criterion	Why Flawed	Testimony
Language	Treatment is not primarily for the purpose of providing custodial care.		<u>Fishman</u> : Tr. 256:9-11, 258:11-15.
after "AND"	Custodial care involves services that don't seek to cure, are provided when the member's condition is unchanging, are not required to maintain stabilization, or don't have to be delivered by trained clinical personnel.	§ II.G.5; PFF § X.E); <u>Custodial/Improvement</u> (see Br. § II.G.8; PFF § X.H)	

3. <u>Discharge Criteria (Ex. 4-0077, third column under "Level of Care Criteria")</u>

¶	Criterion	Why Flawed	Testimony
Language	Care is custodial.	Maintenance of Function (see Br.	Fishman: Tr. 256:9-11, 258:11-15.
after "AND"	 Indications include: The member's signs and symptoms have been stabilized, resolved, or a baseline level of functioning has been achieved; 	§ II.G.5; PFF § X.E); <u>Custodial/Improvement</u> (see Br. § II.G.8; PFF § X.H)	
	 The member's condition is not improving; or The intensity of active treatment in Inpatient [sic] is no longer required. 		

VII. 2015 LEVEL OF CARE GUIDELINES (EX. 5)

A. Common Criteria (Ex. 5-0008 to -0010)

1. Admission Criteria (Ex. 5-0008 to -0009)

¶	Criterion	Why Flawed	Testimony
	The member's current condition cannot be safely, efficiently, and effectively	Acuity (see Br. § II.G.1; PFF	Fishman: Tr. 104:11-105:7; 191:14-193:14;
1.4	assessed and/or treated in a less intensive level of care due to acute changes in	§ X.A); <u>Drive Toward Lower</u>	208:2-16; <u>Plakun</u> : Tr. 523:19-22; 524:8-21;
1.4	the member's signs and symptoms and/or psychosocial and environmental	Levels of Care (see Br. § II.G.3;	Allchin: Tr. 1389:1-1390:14.
	factors (i.e., the "why now" factors leading to admission).	PFF § X.C)	
	The member's current condition can be safely, efficiently, and effectively	Acuity (see Br. § II.G.1; PFF	<u>Fishman</u> : Tr. 104:11-105:7; <u>Plakun</u> : Tr.
	assessed and/or treated in the proposed level of care. Assessment and/or	§ X.A); <u>Drive Toward Lower</u>	523:19-21; 523:23; 524:8-10; 524:17-525:6.
1.5	treatment of acute changes in the member's signs and symptoms and/or	Levels of Care (see Br. § II.G.3;	
1.3	psychosocial and environmental factors (i.e., the "why now" factors leading	PFF § X.C)	
	to admission) require the intensity of services provided in the proposed level		
	of care.		
		Co-occurring (see Br. § II.G.2; PFF	Fishman: Tr. 190:23-191:13; 107:11-108:5;
		§ X.B)	108:7-24; <u>Plakun</u> : Tr. 523:19-21; 523:24-
			524:1; 525:8-25; 526:6-527:1; 527:4-528:25;
1.6	Co-occurring behavioral health and medical conditions can be safely		529:1-14; 529:17-530:2; <u>Niewenhous</u> : Tr.
1.0	managed.		1818:9-1820:18 (discussing Ex. 539);
			<u>Martorana</u> : Tr. 975:15-977:6, 977:8-978:1,
			978:2-21; <u>Simpatico</u> : Tr. 1179:12-1180:1,
			1182:23-1183:6.

¶	Criterion	Why Flawed	Testimony
	There is a reasonable expectation that services will improve the member's	Acuity (see Br. § II.G.1; PFF	Fishman: Tr. 109:3-110:1; 110:2-111:23,
	presenting problems within a reasonable period of time.	§ X.A); Maintenance of Function	112:10-113:4; <u>Plakun</u> : Tr. 530:6-19; 669:10-
	1.8.1. Improvement of the member's condition is indicated by the reduction	(see Br. § II.G.5; PFF § X.E);	20.
	or control of the acute signs and symptoms that necessitated treatment in a	Custodial/Improvement (see Br.	
1.8	level of care.	§ II.G.8; PFF § X.H)	
1.6	1.8.2. Improvement in this context is measured by weighing the effectiveness		
	of treatment against evidence that the member's signs and symptoms will		
	deteriorate if treatment in the current level of care ends. Improvement must		
	also be understood within the broader framework of the member's recovery,		
	resiliency and wellbeing.		
1.9	Treatment is not primarily for the purpose of providing social, custodial,	Custodial/Improvement (see Br.	Fishman: Tr. 250:8-15; 251:25-252:4; Plakun:
1.9	recreational, or respite care.	§ II.G.8; PFF § X.H)	Tr. 581:11-12, 581:24-25, 582:19-21.

2. Continued Service Criteria (Ex. 5-0009)

\P	Criterion	Why Flawed	Testimony
2.1	The admission criteria continue to be met and active treatment is being	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 113:10-114:6; 114:7-13; 135:10-
	provided. For treatment to be considered "active" services must be:	Maintenance of Function (see Br.	136:15; <u>Plakun</u> : Tr. 530:23-531:1; 531:1-13;
	2.1.1. Supervised and evaluated by the admitting provider;	§ II.G.5; PFF § X.E);	531:14-532:2; 532:4-7.
	2.1.2. Provided under an individualized treatment plan that is focused on	Custodial/Improvement (see Br.	
	addressing the "why now" factors, and makes use of clinical best	§ II.G.8; PFF § X.H)	
	practices;		
	2.1.3. Reasonably expected to improve the member's presenting		
	problems within a reasonable period of time.		
2.2	The "why now" factors leading to admission have been identified and are	Acuity (see Br. § II.G.1; PFF § X.A)	Fishman: Tr. 113:25-114:6; 114:7-13.
	integrated into the treatment and discharge plans.		

3. <u>Discharge Criteria (Ex. 5-0009 to -0010)</u>

\P	Criterion	Why Flawed	Testimony
3.1	The continued stay criteria are no longer met. Examples include:	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 114:19-20, 25, 115:1-5, 115:10-
	3.1.1. The "why now" factors which led to admission have been	Drive Toward Lower Levels of Care	24, 116:23-118:1; <u>Plakun</u> : Tr. 532:8-533:3.
	addressed to the extent that the member can be safely transitioned to a	(see Br. § II.G.3; PFF § X.C);	
	less intensive level of care, or no longer requires care.	Maintenance of Function (see Br.	
	3.1.3. Treatment is primarily for the purpose of providing social,	§ II.G.5; PFF § X.E);	
	custodial, recreational, or respite care.	Custodial/Improvement (see Br.	
	3.1.5. The member is unwilling or unable to participate in treatment	§ II.G.8; PFF § X.H); Motivation (see	
	and involuntary treatment or guardianship is not being pursued.	Br. § II.G.6; PFF § X.F)	

B. Intensive Outpatient Program: Mental Health Conditions (Ex. 5-00030 to -0032)

¶	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in an Intensive Outpatient Program is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 583:5-7; 583:14-21.
	addressing the "why now" factors that precipitated admission (e.g., changes	<u>Drive Toward Lower Levels of Care</u>	
	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that the member's condition can		
	be safely, efficiently and effectively treated in a less intensive level of		
	care		

C. Outpatient: Mental Health Conditions (Ex. 5-0033 to -0034)

\P	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in Outpatient is focused on addressing the "why	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 255:16-21.
	now" factors that precipitated admission (e.g., changes in the member's	Maintenance of Function (see Br.	
	signs and symptoms, psychosocial and environmental factors, or level of	§ II.G.5; PFF § X.E)	
	functioning) to the point that the "why now" factors that precipitated		
	admission no longer require treatment.		

1. Admission Criteria (Ex. 5-0033)

\P	Criterion	Why Flawed	Testimony
1.3	Acute changes in the member's signs and symptoms, and/or psychosocial and	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 584:1-2; 584:11-17.
	environmental factors (i.e., the "why now" factors leading to admission) have	Maintenance of Function (see Br.	
	occurred, and the member's current condition can be safely, efficiently, and	§ II.G.5; PFF § X.E)	
	effectively assessed and/or treated in this setting.		

D. Residential Treatment Center: Mental Health Conditions (Ex. 5-0038 to -0040)

¶	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in a Residential Treatment Center is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 584:24-585:8.
	addressing the "why now" factors that precipitated admission (e.g., changes	Drive Toward Lower Levels of Care	
	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that the member's condition can		
	be safely, efficiently and effectively treated in a less intensive level of care.		

1. Admission Criteria (Ex. 5-0038)

\P	Criterion	Why Flawed	Testimony
1.3	The "why now" factors leading to admission cannot be safely, efficiently or	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 584:24-25; 585:10-17.
	effectively assessed and/or treated in a less intensive setting due to acute	Maintenance of Function (see Br.	
	changes in the member's signs and symptoms and/or psychosocial and	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
	environmental factors. Examples include:	Lower Levels of Care (see Br.	
	1.3.1. Acute impairment of behavior or cognition that interferes with	§ II.G.3; PFF § X.C)	
	activities of daily living to the extent that the welfare of the member or		
	others is endangered.		
	1.3.2. Psychosocial and environmental problems that are likely to threaten		
	the member's safety or undermine engagement in a less intensive level of		
	care without the intensity of services offered in this level of care.		

2. Continued Service Criteria (Ex. 5-0038 to -0039)

¶	Criterion	Why Flawed	Testimony
2.2	Treatment is not primarily for the purpose of providing custodial care.	Maintenance of Function (see Br.	<u>Plakun</u> : Tr. 584:24-25; 585:18-22.
	Services are custodial when they are any of the following:	§ II.G.5; PFF § X.E);	
	2.2.2. Health-related services that are provided for the primary purpose of	Custodial/Improvement (see Br.	
	meeting the personal needs of the patient or maintaining a level of function	§ II.G.8; PFF § X.H)	
	(even if the specific services are considered to be skilled services), as		
	opposed to improving that function to an extent that might allow for a		
	more independent existence		
	2.2.3. Services that do not require continued administration by trained		
	medical personnel in order to be delivered safely and effectively.		

E. Intensive Outpatient Program: Substance-Related Disorders (Ex. 5-0055 to -0058)

¶	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in an Intensive Outpatient Program is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 254:15-24
	addressing the "why now" factors that precipitated admission (e.g., changes	Drive Toward Lower Levels of Care	
	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that the member's condition can		
	be safely, efficiently and effectively treated in a less intensive level of care.		

F. Outpatient: Substance-Related Disorders (Ex. 5-0070 to -0072)

¶	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in Outpatient is focused on addressing the "why	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 255:16-21.
	now" factors that precipitated admission (e.g., changes in the member's	Maintenance of Function (see Br.	
	signs and symptoms, psychosocial and environmental factors, or level of	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
	functioning) to the point that the "why now" factors that precipitated	Lower Levels of Care (see Br.	
	admission no longer require treatment.	§ II.G.3; PFF § X.C)	

1. Admission Criteria (Ex. 5-0070)

\P	Criterion	Why Flawed	Testimony
1.4	Acute changes in the member's signs and symptoms, and/or psychosocial and	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 130:2-24; 130:25-131:18.
	environmental factors (i.e., the "why now" factors leading to admission) have	Maintenance of Function (see Br.	
	occurred, and the member's current condition can be safely, efficiently, and	§ II.G.5; PFF § X.E)	
	effectively assessed and/or treated in this setting.		

G. Residential Rehabilitation: Substance-Related Disorders (Ex. 5-0081 to -0083)

¶	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in Residential Rehabilitation is focused on addressing the "why now" factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that rehabilitation can be safely, efficiently and effectively continued in a less intensive level of care.	Acuity (see Br. § II.G.1; PFF § X.A); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	Fishman: Tr. 256:9-18.

1. Admission Criteria (Ex. 5-0081)

¶	Criterion	Why Flawed	Testimony
1.3	The "why now" factors leading to admission and/or the member's history of	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 124:16-22; 125:10-14; <u>Alam</u> :
	response to treatment suggest that there is imminent or current risk of relapse	Maintenance of Function (see Br.	Tr. 1601:5-1602:12.
	which cannot be safely, efficiently, and effectively managed in a less	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
	intensive level of care. Examples include:	Lower Levels of Care (see Br.	
		§ II.G.3; PFF § X.C)	
	1.3.1. A co-occurring mental health condition is stabilizing but the remaining		
	signs and symptoms are likely to undermine treatment in a less intensive		
	setting.		
	1.3.2. The member is in immediate or imminent danger of relapse, and the		
	history of treatment suggests that the structure and support provided in this		
	level of care is needed to control the recurrence.		

\P	Criterion	Why Flawed	Testimony
1.4	The "why now" factors leading to admission cannot be safely, efficiently, or	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 124:16-22; 125:10-14.
	effectively assessed and/or treated in a less intensive setting due to acute	<u>Drive Toward Lower Levels of Care</u>	
	changes in the member's signs and symptoms, and/or psychosocial and	(see Br. § II.G.3; PFF § X.C)	
	environmental factors. Examples include:		
	1.4.1. Acute impairment of behavior or cognition is interfering with Activities of Daily Living to the extent that the welfare of the member or others is endangered.		
	1.4.2. Psychosocial and environmental problems threaten the member's safety, or undermine engagement in a less intensive level of care.		

2. Continued Service Criteria (Ex. 5-0082)

\P	Criterion	Why Flawed	Testimony
2.2.3	Treatment is not primarily for the purpose of providing custodial care.	Maintenance of Function (see Br.	<u>Fishman</u> : Tr. 125:1-6; 125:15-126:16.
	Services are custodial when they are any of the following:	§ II.G.5; PFF § X.E);	
	2.2.2. Health-related services provided for the primary purpose of meeting the	<u>Custodial/Improvement</u> (see Br. § II.G.8; PFF § X.H)	
	personal needs of the patient or maintaining a level of function (even if the		
	specific services are considered to be skilled services), as opposed to		
	improving that function to an extent that might allow for a more independent		
	existence.		
	2.2.3. Services that do not require continued administration by trained		
	medical personnel in order to be delivered safely and effectively.		

VIII. 2016 LEVEL OF CARE GUIDELINES (EX. 6)

A. Common Criteria (Ex. 6-0009 to -0011)

1. Admission Criteria (Ex. 6-0009 to -0010)

\P	Criterion	Why Flawed	Testimony
1.4	The member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors (i.e., the "why now" factors leading to admission).	Acuity (see Br. § II.G.1; PFF § X.A); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	<u>Fishman</u> : Tr. 260:9-261:9; <u>Plakun</u> : Tr. 548:18-23; 548:25-549:4; <u>Allchin</u> : Tr. 1389:1-1390:14.
1.5	The member's current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of acute changes in the member's signs and symptoms and/or psychosocial and environmental factors (i.e., the "why now" factors leading to admission) require the intensity of services provided in the proposed level of care.	Acuity (see Br. § II.G.1; PFF § X.A); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	<u>Fishman</u> : Tr. 261:4-5; 261:10-11; <u>Plakun</u> : 548:18-23, 548:25-549:4.
1.6	Co-occurring behavioral health and medical conditions can be safely managed.	Co-occurring (see Br. § II.G.2; PFF § X.B)	<u>Fishman</u> : Tr. 261:4-5; 261:12-18; <u>Plakun</u> : Tr. 548:18-23; 548:25-549:4; <u>Allchin</u> : Tr. 1389:1-1390:14; <u>Martorana</u> : Tr. 975:15-977:6, 977:8-978:1, 978:2-21; <u>Simpatico</u> : Tr. 1179:12-1180:1, 1182:23-1183:6.

\P	Criterion	Why Flawed	Testimony
	There is a reasonable expectation that services will improve the member's	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : 261:4-5; 261:19-262:2; <u>Plakun</u> : Tr.
	presenting problems within a reasonable period of time.	Maintenance of Function (see Br.	548:18-23, 548:25-549:4.
		§ II.G.5; PFF § X.E);	
	1.8.1. Improvement of the member's condition is indicated by the reduction	<u>Custodial/Improvement</u> (see Br.	
	or control of the acute signs and symptoms that necessitated treatment in a	§ II.G.8; PFF § X.H)	
1.8	level of care.		
	1.8.2. Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member's recovery, resiliency and wellbeing.		
1.9	Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.	Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	<u>Fishman</u> : Tr. 250:8-15; 251:25-252:4; <u>Plakun</u> : Tr. 581:11-12, 581:24-25, 582:19-21.

2. Continued Service Criteria (Ex. 6-0010)

\P	Criterion	Why Flawed	Testimony
2.1	The admission criteria continue to be met and active treatment is being	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 262:3-7; Plakun: Tr. 549:10-17.
	provided. For treatment to be considered "active" services must be as	Maintenance of Function (see Br.	
	follows:	§ II.G.5; PFF § X.E);	
		Custodial/Improvement (see Br.	
	2.1.1. Supervised and evaluated by the admitting provider;	§ II.G.8; PFF § X.H)	
	2.1.2. Provided under an individualized treatment plan that is focused on addressing the "why now" factors, and makes use of clinical best practices;		
	2.1.3. Reasonably expected to improve the member's presenting problems within a reasonable period of time.		
2.2	The "why now" factors leading to admission have been identified and are integrated into the treatment and discharge plans.	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 262:3-10.

3. <u>Discharge Criteria (Ex. 6-0010 to -0011)</u>

¶	Criterion	Why Flawed	Testimony
3.1	The continued stay criteria are no longer met. Examples include:	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 262:11-12, 262:13-16; Plakun:
		Drive Toward Lower Levels of Care	Tr. 549:20-550:2.
	3.1.1. The "why now" factors which led to admission have been addressed	(see Br. § II.G.3; PFF § X.C);	
	to the extent that the member can be safely transitioned to a less intensive	Maintenance of Function (see Br.	
	level of care, or no longer requires care.	§ II.G.5; PFF § X.E);	
	3.1.3. Treatment is primarily for the purpose of providing social,	Custodial/Improvement (see Br.	
	custodial, recreational, or respite care.	§ II.G.8; PFF § X.H); Motivation (see	
	3.1.5. The member is unwilling or unable to participate in treatment and	Br. § II.G.6; PFF § X.F)	
	involuntary treatment or guardianship is not being pursued.		

B. Intensive Outpatient Program: Mental Health Conditions (Ex. 6-00032 to -0035)

\P	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in an Intensive Outpatient Program is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 585:25-586:10; 656:3-22.
	addressing the "why now" factors that precipitated admission (e.g., changes	Drive Toward Lower Levels of Care	
	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that the member's condition can		
	be safely, efficiently and effectively treated in a less intensive level of		
	care		

C. Outpatient: Mental Health Conditions (Ex. 6-0036 to -0038)

¶	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in Outpatient is focused on addressing the "why	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 586:16-24.
	now" factors that precipitated admission (e.g., changes in the member's	Maintenance of Function (see Br.	
	signs and symptoms, psychosocial and environmental factors, or level of	§ II.G.5; PFF § X.E).	
	functioning) to the point that the "why now" factors that precipitated		
	admission no longer require treatment.		

1. Admission Criteria (Ex. 6-0036)

\P	Criterion	Why Flawed	Testimony
	Acute changes in the member's signs and symptoms, and/or psychosocial	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 586:25-587:2-10.
1.3	and environmental factors (i.e., the "why now" factors leading to	Maintenance of Function (see Br.	
	admission) have occurred, and the member's current condition can be	§ II.G.5; PFF § X.E);	
	safely, efficiently, and effectively assessed and/or treated in this setting.		

D. Residential Treatment Center: Mental Health Conditions (Ex. 6-0043 to -0045)

\P	Criterion	Why Flawed	Testimony
	The course of treatment in a Residential Treatment Center is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 587:15-21.
Preamble	addressing the "why now" factors that precipitated admission (e.g., changes	Drive Toward Lower Levels of Care	
	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that the member's condition can		
	be safely, efficiently and effectively treated in a less intensive level of care.		

2. Admission Criteria (Ex. 6-0043)

¶	Criterion	Why Flawed	Testimony
	The "why now" factors leading to admission cannot be safely, efficiently or	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 587:15-17; 587:22-588:2; 588:8-
1.3	effectively assessed and/or treated in a less intensive setting due to acute	Maintenance of Function (see Br.	16; 588:19-21.
	changes in the member's signs and symptoms and/or psychosocial and	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
	environmental factors. Examples including the following:	Lower Levels of Care (see Br.	
		§ II.G.3; PFF § X.C)	
	1.3.1. Acute impairment of behavior or cognition that interferes with		
	activities of daily living to the extent that the welfare of the member or others		
	is endangered.		
	1.3.2. Psychosocial and environmental problems that are likely to threaten the		
	member's safety or undermine engagement in a less intensive level of care		
	without the intensity of services offered in this level of care.		

3. Continued Service Criteria (Ex. 6-0043 to -0044)

\P	Criterion	Why Flawed	Testimony
	Treatment is not primarily for the purpose of providing custodial care.	Maintenance of Function (see Br.	<u>Plakun</u> : Tr. 587:15-17; 588:3-7.
2.2	Services are custodial when they are any of the following:	§ II.G.5; PFF § X.E);	
		Custodial/Improvement (see Br.	
	2.2.2. Health-related services provided for the primary purpose of meeting the	§ II.G.8; PFF § X.H);	
	personal needs of the patient or maintaining a level of function (even if the		
	specific services are considered to be skilled services), as opposed to		
	improving that function to an extent that might allow for a more independent		
	existence;		
	2.2.3. Services that do not require continued administration by trained		
	medical personnel in order to be delivered safely and effectively.		

E. Intensive Outpatient Program: Substance-Related Disorders (Ex. 6-0062 to -0065)

¶	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in an Intensive Outpatient Program is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 262:18-263:2.
	addressing the "why now" factors that precipitated admission (e.g., changes	<u>Drive Toward Lower Levels of Care</u>	
	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that the member's condition can		
	be safely, efficiently and effectively treated in a less intensive level of		
	care		

F. Outpatient: Substance-Related Disorders (Ex. 6-0079 to -0081)

\P	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in Outpatient is focused on addressing the "why	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 263:6-11.
	now" factors that precipitated admission (e.g., changes in the member's signs	Maintenance of Function (see Br.	
	and symptoms, psychosocial and environmental factors, or level of	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
	functioning) to the point that the "why now" factors that precipitated	Lower Levels of Care (see Br.	
	admission no longer require treatment.	§ II.G.3; PFF § X.C)	

1. Admission Criteria (Ex. 6-0079)

¶	Criterion	Why Flawed	Testimony
1.4	Acute changes in the member's signs and symptoms, and/or psychosocial and	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 263:12-20.
	environmental factors (i.e., the "why now" factors leading to admission) have	Maintenance of Function (see Br.	
	occurred, and the member's current condition can be safely, efficiently, and	§ II.G.5; PFF § X.E);	
	effectively assessed and/or treated in this setting.		

G. Residential Rehabilitation: Substance-Related Disorders (Ex. 6-0090 to -0092)

\P	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in Residential Rehabilitation is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 263:22-264:2.
	addressing the "why now" factors that precipitated admission (e.g., changes	Drive Toward Lower Levels of Care	
	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that rehabilitation can be safely,		
	efficiently and effectively continued in a less intensive level of care.		

1. Admission Criteria (Ex. 6-0090 to -0091)

\P	Criterion	Why Flawed	Testimony
1.3	The "why now" factors leading to admission and/or the member's history of	Acuity (see Br. § II.G.1; PFF	Fishman: Tr. 263:22-264:8.
	response to treatment suggest that there is imminent or current risk of relapse	§ X.A); Maintenance of Function	
	which cannot be safely, efficiently, and effectively managed in a less intensive	(see Br. § II.G.5; PFF § X.E); <u>Drive</u>	
	level of care.	Toward Lower Levels of Care (see	
	1.3.1. A co-occurring mental health condition is stabilizing but the	Br. § II.G.3; PFF § X.C)	
	remaining signs and symptoms are likely to undermine treatment in a less		
	intensive setting.		
	1.3.2. The member is in immediate or imminent danger of relapse, and the		
	history of treatment suggests that the structure and support provided in this		
	level of care is needed to control the recurrence.		
1.4	The "why now" factors leading to admission cannot be safely, efficiently, or	Acuity (see Br. § II.G.1; PFF	Fishman: Tr. 263:22-264:10.
	effectively assessed and/or treated in a less intensive setting due to acute	§ X.A); <u>Drive Toward Lower</u>	
	changes in the member's signs and symptoms, and/or psychosocial and	Levels of Care (see Br. § II.G.3;	
	environmental factors.	PFF § X.C)	

2. Continued Service Criteria (Ex. 6-0091)

Criterion	Why Flawed	Testimony
Treatment is not primarily for the purpose of providing custodial care. Services	Maintenance of Function (see Br.	<u>Fishman</u> : Tr. 263:22-264:19.
are custodial when they are any of the following:	§ II.G.5; PFF § X.E);	
	Custodial/Improvement (see Br.	
	§ II.G.8; PFF § X.H)	
1 // 11		
existence.		
2.2.3 Services that do not require continued administration by trained medical		
	Treatment is not primarily for the purpose of providing custodial care. Services	Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following: 2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence. 2.2.3. Services that do not require continued administration by trained medical

X. <u>2016 LEVEL OF CARE GUIDELINES (EX. 7)</u>

A. Common Criteria (Ex. 7-0009 to -0011)

1. Admission Criteria (Ex. 7-0009 to -0010)

\P	Criterion	Why Flawed	Testimony
1.4	The member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors (i.e., the "why now" factors leading to admission).	Acuity (see Br. § II.G.1; PFF § X.A); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	<u>Fishman</u> : Tr. 260:9-261:9; <u>Plakun</u> : Tr. 548:18-23; 548:25-549:4; 550:23-551:5; <u>Allchin</u> : Tr. 1389:1-1390:14.
1.5	The member's current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of acute changes in the member's signs and symptoms and/or psychosocial and environmental factors (i.e., the "why now" factors leading to admission) require the intensity of services provided in the proposed level of care.	Acuity (see Br. § II.G.1; PFF § X.A); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	<u>Fishman</u> : Tr. 261:4-5; 261:10-11; <u>Plakun</u> : 548:18-23, 548:25-549:4, 550:23-551:5.
1.6	Co-occurring behavioral health and medical conditions can be safely managed.	Co-occurring (see Br. § II.G.2; PFF § X.B)	Fishman: Tr. 261:4-5; 261:12-18; Plakun: Tr. 548:18-23; 548:25-549:4, 550:23-551:5; Martorana: Tr. 975:15-977:6, 977:8-978:1, 978:2-21; Simpatico: Tr. 1179:12-1180:1, 1182:23-1183:6.

¶	Criterion	Why Flawed	Testimony
	There is a reasonable expectation that services will improve the member's	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : 261:4-5; 261:19-262:2; <u>Plakun</u> : Tr.
	presenting problems within a reasonable period of time.	Maintenance of Function (see Br.	548:18-23, 548:25-549:4, 550:23-551:5.
		§ II.G.5; PFF § X.E);	
	1.8.1. Improvement of the member's condition is indicated by the reduction	Custodial/Improvement (see Br.	
	or control of the acute signs and symptoms that necessitated treatment in a	§ II.G.8; PFF § X.H)	
1.8	level of care.		
110	1.8.2. Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member's recovery, resiliency and wellbeing.		
1.9	Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.	<u>Custodial/Improvement</u> (see Br. § II.G.8; PFF § X.H)	<u>Fishman</u> : Tr. 250:8-15; 251:25-252:4; <u>Plakun</u> : Tr. 581:11-12, 581:24-25, 582:19-21.

2. Continued Service Criteria (Ex. 7-0010)

\P	Criterion	Why Flawed	Testimony
	The admission criteria continue to be met and active treatment is being	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 550:23-551:3; 551:7-8.
	provided. For treatment to be considered "active" services must be as	Maintenance of Function (see Br.	
	follows:	§ II.G.5; PFF § X.E);	
		Custodial/Improvement (see Br.	
2.1	2.1.1. Supervised and evaluated by the admitting provider;	§ II.G.8; PFF § X.H)	
2.1	2.1.2. Provided under an individualized treatment plan that is focused on addressing the "why now" factors, and makes use of clinical best practices;		
	2.1.3. Reasonably expected to improve the member's presenting problems within a reasonable period of time.		
2.2	The "why now" factors leading to admission have been identified and are	Acuity (see Br. § II.G.1; PFF § X.A)	<u>Fishman</u> : Tr. 113:25-114:6; 114:7-13.
	integrated into the treatment and discharge plans.		

3. <u>Discharge Criteria (Ex. 7-0010 to -0011)</u>

¶	Criterion	Why Flawed	Testimony
	The continued stay criteria are no longer met. Examples include:	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 550:23-551:3; 551:9-10.
		<u>Drive Toward Lower Levels of Care</u>	
	3.1.1. The "why now" factors which led to admission have been addressed	(see Br. § II.G.3; PFF § X.C);	
	to the extent that the member can be safely transitioned to a less intensive	Maintenance of Function (see Br.	
3.1	level of care, or no longer requires care.	§ II.G.5; PFF § X.E);	
	3.1.3. Treatment is primarily for the purpose of providing social,	Custodial/Improvement (see Br.	
	custodial, recreational, or respite care.	§ II.G.8; PFF § X.H); Motivation (see	
	3.1.5. The member is unwilling or unable to participate in treatment and	Br. § II.G.6; PFF § X.F)	
	involuntary treatment or guardianship is not being pursued.	,	

B. Intensive Outpatient Program: Mental Health Conditions (Ex. 7-0032 to -0035)

\P	Criterion	Why Flawed	Testimony
	The course of treatment in an Intensive Outpatient Program is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 591:24, 592:2-14, 657:20-658:1.
	addressing the "why now" factors that precipitated admission (e.g., changes	Drive Toward Lower Levels of Care	
Preamble	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that the member's condition can		
	be safely, efficiently and effectively treated in a less intensive level of care.		

C. Outpatient: Mental Health Conditions (Ex. 7-0036 to -0038)

\P	Criterion	Why Flawed	Testimony
	The course of treatment in Outpatient is focused on addressing the "why	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 590:2-6.
	now" factors that precipitated admission (e.g., changes in the member's	Maintenance of Function (see Br.	
Preamble	signs and symptoms, psychosocial and environmental factors, or level of	§ II.G.5; PFF § X.E);	
	functioning) to the point that the "why now" factors that precipitated		
	admission no longer require treatment.		

1. Admission Criteria (Ex. 7-0036)

\P	Criterion	Why Flawed	Testimony
	Acute changes in the member's signs and symptoms, and/or psychosocial	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 590:2-3; 590:7-9.
1.2	and environmental factors (i.e., the "why now" factors leading to	Maintenance of Function (see Br.	
1.3	admission) have occurred, and the member's current condition can be	§ II.G.5; PFF § X.E)	
	safely, efficiently, and effectively assessed and/or treated in this setting.		

D. Residential Treatment Center: Mental Health Conditions (Ex. 7-0043 to -0045)

\P	Criterion	Why Flawed	Testimony
	The course of treatment in a Residential Treatment Center is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 590:11-16.
	addressing the "why now" factors that precipitated admission (e.g., changes	Drive Toward Lower Levels of Care	
Preamble	in the member's signs and symptoms, psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
	factors, or level of functioning) to the point that the member's condition can		
	be safely, efficiently and effectively treated in a less intensive level of care.		

1. Admission Criteria (Ex. 7-0043)

¶	Criterion	Why Flawed	Testimony
	The "why now" factors leading to admission cannot be safely, efficiently or	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 590:11-12; 590:17-20.
	effectively assessed and/or treated in a less intensive setting due to acute	Maintenance of Function (see Br.	
	changes in the member's signs and symptoms and/or psychosocial and	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
	environmental factors. Examples include the following:	Lower Levels of Care (see Br.	
		§ II.G.3; PFF § X.C)	
1.3	1.3.1. Acute impairment of behavior or cognition that interferes with		
1.3	activities of daily living to the extent that the welfare of the member or		
	others is endangered.		
	1.3.2. Psychosocial and environmental problems that are likely to threaten		
	the member's safety or undermine engagement in a less intensive level of		
	care without the intensity of services offered in this level of care.		

2. Continued Service Criteria (Ex. 7-0043 to -0044)

¶	Criterion	Why Flawed	Testimony
	Treatment is not primarily for the purpose of providing custodial care.	Maintenance of Function (see Br.	<u>Plakun</u> : Tr. 590:11-12.
	Services are custodial when they are any of the following:	§ II.G.5; PFF § X.E);	
		Custodial/Improvement (see Br.	
	2.2.2. Health-related services provided for the primary purpose of meeting	§ II.G.8; PFF § X.H)	
	the personal needs of the patient or maintaining a level of function (even if		
2.2	the specific services are considered to be skilled services), as opposed to		
	improving that function to an extent that might allow for a more		
	independent existence;		
	2.2.3. Services that do not require continued administration by trained		
	medical personnel in order to be delivered safely and effectively.		

E. Intensive Outpatient Program: Substance-Related Disorders (Ex. 7-0062 to -0066)

\P	Criterion	Why Flawed	Testimony
	The course of treatment in an Intensive Outpatient Program is focused on	Acuity (see Br. § II.G.1; PFF	<u>Fishman</u> : Tr. 206:17-207:16.
	addressing the "why now" factors that precipitated admission (e.g., changes	§ X.A); <u>Drive Toward Lower</u>	
Preamble	in the member's signs and symptoms, psychosocial and environmental	Levels of Care (see Br. § II.G.3;	
	factors, or level of functioning) to the point that the member's condition can	PFF § X.C)	
	be safely, efficiently and effectively treated in a less intensive level of care.		

F. Outpatient: Substance-Related Disorders (Ex. 7-0080 to -0082)

¶	Criterion	Why Flawed	Testimony
	The course of treatment in Outpatient is focused on addressing the "why	Acuity (see Br. § II.G.1; PFF	<u>Fishman</u> : Tr. 255:16-21.
	now" factors that precipitated admission (e.g., changes in the member's signs	§ X.A); Maintenance of Function	
Preamble	and symptoms, psychosocial and environmental factors, or level of	(see Br. § II.G.5; PFF § X.E); <u>Drive</u>	
	functioning) to the point that the "why now" factors that precipitated	Toward Lower Levels of Care (see	
	admission no longer require treatment.	Br. § II.G.3; PFF § X.C)	

3. Admission Criteria (Ex. 7-0080)

\P	Criterion	Why Flawed	Testimony
	Acute changes in the member's signs and symptoms, and/or psychosocial and	Acuity (see Br. § II.G.1; PFF	<u>Fishman</u> : Tr. 263:12-20.
1.4	environmental factors (i.e.; the "why now" factors leading to admission) have	§ X.A). Maintenance of Function	
1.4	occurred, and the member's current condition can be safely, efficiently, and	(see Br. § II.G.5; PFF § X.E);	
	effectively assessed and/or treated in this setting.		

G. Residential Rehabilitation: Substance-Related Disorders (Ex. 7-0091 to -0093)

\P	Criterion	Why Flawed	Testimony
	The course of treatment in Residential Rehabilitation is focused on	Acuity (see Br. § II.G.1; PFF	<u>Fishman</u> : Tr. 263:22-264:2.
	addressing the "why now" factors that precipitated admission (e.g., changes	§ X.A); <u>Drive Toward Lower</u>	
Preamble	in the member's signs and symptoms, psychosocial and environmental	Levels of Care (see Br. § II.G.3;	
	factors, or level of functioning) to the point that rehabilitation can be safely,	PFF § X.C)	
	efficiently and effectively continued in a less intensive level of care.		

1. Admission Criteria (Ex. 7-0091 to -0092)

9	Criterion	Why Flawed	Testimony
1.3	The "why now" factors leading to admission and/or the member's history of response to treatment suggest that there is imminent or current risk of relapse which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include: 1.3.1. A co-occurring mental health condition is stabilizing but the remaining signs and symptoms are likely to undermine treatment in a less intensive setting.	V	Fishman: Tr. 263:22-264:8.
	1.3.2. The member is in immediate or imminent danger of relapse, and the history of treatment suggests that the structure and support provided in this level of care is needed to control the recurrence.		

\P	Criterion	Why Flawed	Testimony
1.4	The "why now" factors leading to admission cannot be safely, efficiently, or effectively assessed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors. Examples include: 1.4.1. Acute impairment of behavior or cognition is interfering with Activities of Daily Living to the extent that the welfare of the member or others is endangered.	Acuity (see Br. § II.G.1; PFF § X.A); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	Fishman: Tr. 263:22-264:10.
	1.4.2. Psychosocial and environmental problems threaten the member's safety, or undermine engagement in a less intensive level of care.		

2. Continued Service Criteria (Ex. 7-0092)

9		Criterion	Why Flawed	Testimony
2.	2	Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following: 2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	Fishman: Tr. 250:8-15; 251:25-252:4; Plakun: Tr. 581:11-12, 581:24-25, 582:19-21, 590:11-12.
		2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.		

XI. 2017 LEVEL OF CARE GUIDELINES (EX. 8)

A. Common Criteria (Ex. 8-0006 to -0007, Ex. 8-0011 to -0012 & Ex. 8-0024 to -0025)

1. Admission Criteria (Ex. 8-0006 to -0007; Ex. 8-0011, Ex. 8-0024)

\P	Criterion	Why Flawed	Testimony
4th	The member's current condition cannot be safely, efficiently, and effectively	Drive Toward Lower Levels of Care	Fishman: Tr. 261:4-5; 261:10-11; Plakun:
black	assessed and/or treated in a less intensive level of care.	(see Br. § II.G.3; PFF § X.C)	548:18-23, 548:25-549:4, 550:23-551:5.
bullet			
(page 8-			
0007			
5 th black	The member's current condition can be safely, efficiently, and effectively	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 261:4-5; 261:10-11; <u>Plakun</u> :
bullet	assessed and/or treated in the proposed level of care. Assessment and/or	<u>Drive Toward Lower Levels of Care</u>	548:18-23, 548:25-549:4, 550:23-551:5.
(page 8-	treatment of the factors leading to admission require the intensity of services	(see Br. § II.G.3; PFF § X.C)	
0007)	provided in the proposed level of care.		
6th	Co-occurring behavioral health and medical conditions can be safely	Co-occurring (see Br. § II.G.2; PFF	<u>Plakun</u> : Tr. 552:19-22, 553:1-3; <u>Martorana</u> :
black	managed.	§ X.B)	Tr. 975:15-977:6, 977:8-978:1, 978:2-21;
bullet			Simpatico: Tr. 1179:12-1180:1, 1182:23-
(page 8-			1183:6.
0007)			
8th	There is a reasonable expectation that service(s) will improve the member's	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 267:10-20, 267:21-23; <u>Plakun</u> :
black	presenting problems within a reasonable period of time.	Maintenance of Function (see Br.	Tr. 552:19-22, 553:4-8, 555:15-22, 555:24-
bullet	o Improvement of the member's condition is indicated by the reduction	§ II.G.5; PFF § X.E);	556:2; Martorana: Tr. 1129:11-1130:11,
and sub-	or control of the signs and symptoms that necessitated treatment in a	Custodial/Improvement (see Br.	1130:12-14.
bullets	level of care.	§ II.G.8; PFF § X.H)	
(page 8-	 Improvement in this context is measured by weighing the 		
0007)	effectiveness of treatment against evidence that the member's signs		
	and symptoms will deteriorate if treatment in the current level of care		
	ends. Improvement must also be understood within the broader		
	framework of the member's recovery, resiliency, and wellbeing.		

2. <u>Continued Service Criteria (Ex. 8-0007, Ex. 8-0011, Ex. 8-0024)</u>

\P	Criterion	Why Flawed	Testimony
1st black	The admission criteria continue to be met and active treatment is being	Acuity (see Br. § II.G.1; PFF § X.A);	Plakun: Tr. 552:19-22, 553:15-23.
bullet	provided. For treatment to be considered "active", service(s) must be as	Maintenance of Function (see Br.	
and sub-	follows:	§ II.G.5; PFF § X.E);	
bullets	 Supervised and evaluated by the admitting provider; 	<u>Custodial/Improvement</u> (see Br.	
(pages	o Provided under an individualized treatment plan that is focused on	§ II.G.8; PFF § X.H)	
8-0007, -	addressing the factors leading to admission, and makes use of clinical		
0011,	best practices;		
and -	o Reasonably expected to improve the member's presenting problems		
0024)	within a reasonable period of time.		

3. <u>Discharge Criteria (Ex. 8-0007, Ex. 8-0011 to -0012, Ex. 8-0024 to -0025)</u>

¶	Criterion	Why Flawed	Testimony
1st black	The continued stay criteria are no longer met. Examples include:	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 268:06-13, 268:14-20; Plakun:
bullet	o The factors which led to admission have been addressed to the extent	Drive Toward Lower Levels of Care	Tr. 552:19-22, 553:25-554:5; <u>Martorana</u> : Tr.
and sub-	that the member can be safely transitioned to a less intensive level of	(see Br. § II.G.3; PFF § X.C);	994:10-998:19.
bullets	care, or no longer requires care.	Maintenance of Function (see Br.	
(pages	•••	§ II.G.5; PFF § X.E)	
8-0007, -	o Treatment is primarily for the purpose of providing social, custodial,	Custodial/Improvement (see Br.	
0011 to -	recreational, or respite care.	§ II.G.8; PFF § X.H); Motivation (see	
0012,	•••	Br. § II.G.6; PFF § X.F)	
and -	o The member is unwilling or unable to participate in treatment, and		
0024 to -	involuntary treatment or guardianship is not being pursued.		
025)			

B. Outpatient: Mental Health Conditions (Ex. 8-0013 to -0014)

¶	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in Outpatient is focused on addressing the	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 591:24, 592:2-14, 657:20-658:1.
	factors that precipitated admission (e.g., changes in the member's signs and	Maintenance of Function (see Br.	
	symptoms, psychosocial and environmental factors, or level of functioning)	§ II.G.5; PFF § X.E)	
	to the point that the factors that precipitated admission no longer require		
	treatment. Individual outpatient psychotherapy is generally provided in		
	sessions lasting up to 45 minutes.		

C. Intensive Outpatient Program: Mental Health Conditions (Ex. 8-0014 to -0015)

\P	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in an Intensive Outpatient Program is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 591:24, 592:2-14, 657:20-658:1.
	addressing the factors that precipitated admission (e.g., changes in the	<u>Drive Toward Lower Levels of Care</u>	
	member's signs and symptoms, psychosocial and environmental factors, or	(see Br. § II.G.3; PFF § X.C)	
	level of functioning) to the point that the member's condition can be safely,		
	efficiently and effectively treated in a less intensive level of care.		

D. Residential Treatment Center: Mental Health Conditions (Ex. 8-0018 to -0019)

\P	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in a Residential Treatment Center is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 592:20-593:4.
	addressing the factors that precipitated admission (e.g., changes in the	Drive Toward Lower Levels of Care	
	member's signs and symptoms, psychosocial and environmental factors, or	(see Br. § II.G.3; PFF § X.C)	
	level of functioning) to the point that the member's condition can be safely,		
	efficiently and effectively treated in a less intensive level of care		

1. Admission Criteria (Ex. 8-0018)

\P	Criterion	Why Flawed	Testimony
3rd	The factors leading to admission cannot be safely, efficiently, or effectively	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Plakun</u> : Tr. 592:20-21, 593:5-11.
black	assessed and/or treated in a less intensive setting due to acute changes in the	Maintenance of Function (see Br.	
bullet	member's signs and symptoms and/or psychosocial and environmental	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
and sub-	factors. Examples include the following:	Lower Levels of Care (see Br.	
bullets	 Acute impairment of behavior or cognition that interferes with 	§ II.G.3; PFF § X.C)	
(page 8-	activities of daily living to the extent that the welfare of the member		
0018)	or others is endangered.		
	 Psychosocial and environmental problems that are likely to threaten 		
	the member's safety or undermine engagement in a less intensive level		
	of care without the intensity of services offered in this level of care.		

2. Continued Service Criteria (Ex. 8-0018 to -0019)

¶	Criterion	Why Flawed	Testimony
2nd	Treatment is not primarily for the purpose of providing custodial care.	Maintenance of Function (see Br.	<u>Plakun</u> : Tr. 592:20-21, 593:5-11; <u>Martorana</u> :
black	Services are custodial when they are any of the following:	§ II.G.5; PFF § X.E)	Tr. 1006:15-1007:2.
bullet	 Health-related services provided for the primary purpose of meeting 	Custodial/Improvement (see Br.	
and sub-	the personal needs of the patient or maintaining a level of function	§ II.G.8; PFF § X.H)	
bullets	(even if the specific services are considered to be skilled services), as		
(pages	opposed to improving that function to an extent that might allow for a		
8-0018	more independent existence;		
to -	 Services that do not require continued administration by trained 		
0019)	medical personnel in order to be delivered safely and effectively.		

E. Outpatient: Substance-Related Disorders (Ex. 8-0026 to -0027)

\P	Criterion	Why Flawed	Testimony
Preamble	Assessment and diagnosis and active behavioral health treatment that are	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 269:8-270:7.
	provided in an ambulatory setting. The course of treatment in Outpatient is	Maintenance of Function (see Br.	
	focused on addressing the factors that precipitated admission (e.g., changes	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
	in the member's signs and symptoms, psychosocial and environmental	Lower Levels of Care (see Br.	
	factors, or level of functioning) to the point that the factors that precipitated	§ II.G.3; PFF § X.C)	
	admission no longer require treatment. Individual outpatient psychotherapy		
	is generally provided in sessions lasting up to 45 minutes.		
	Extended outpatient sessions are individual psychotherapy sessions with or without evaluation and management services lasting longer than 95 minutes. Extended outpatient sessions require pre-service notification before services are received, except in extenuating circumstances, such as a crisis when notification should occur as soon as possible. In the event that the Mental Health/Substance Use Disorder Designee is not notified of extended outpatient sessions, benefits may be reduced. Check the member's specific plan document for the applicable penalty and allowance of a grace period.		

F. Intensive-Outpatient Program: Substance-Related Disorders (Ex. 8-0032 to -0033)

\P	Criterion	Why Flawed	Testimony
Preamble	The course of treatment in an Intensive Outpatient Program is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	Fishman: Tr. 271:18-272:1.
	addressing the factors that precipitated admission (e.g., changes in the	<u>Drive Toward Lower Levels of Care</u>	
	member's signs and symptoms, psychosocial and environmental factors, or	(see Br. § II.G.3; PFF § X.C)	
	level of functioning) to the point that the member's condition can be safely,		
	efficiently and effectively treated in a less intensive level of care		

G. Residential Rehabilitation: Substance-Related Disorders (Ex. 8-0035 to -0036)

Criterion	Why Flawed	Testimony
The course of treatment in Residential Rehabilitation is focused on	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 272:2-8.
addressing the factors that precipitated admission (e.g., changes in the	<u>Drive Toward Lower Levels of Care</u>	
member's signs and symptoms, psychosocial and environmental factors, or	(see Br. § II.G.3; PFF § X.C)	
level of functioning) to the point that rehabilitation can be safely, efficiently		
and effectively continued in a less intensive level of care.		
		The course of treatment in Residential Rehabilitation is focused on addressing the factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that rehabilitation can be safely, efficiently Acuity (see Br. § II.G.1; PFF § X.A); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)

1. Admission Criteria (Ex. 8-0035 to -0036)

¶	Criterion	Why Flawed	Testimony
3rd	The factors leading to admission and/or the member's history of response to	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 272:9-19.
black	treatment suggest that there is imminent or current risk of relapse which	Maintenance of Function (see Br.	
bullet	cannot be safely, efficiently, and effectively managed in a less intensive level	§ II.G.5; PFF § X.E); <u>Drive Toward</u>	
and sub-	of care.	Lower Levels of Care (see Br.	
bullets (page 8- 0035)	 A co-occurring mental health condition is stabilizing but the remaining signs and symptoms are likely to undermine treatment in a less intensive setting. The member is in immediate or imminent danger of relapse, and the history of treatment suggests that the structure and support provided in this level of care is needed to control the recurrence. 	§ II.G.3; PFF § X.C)	
4th	The factors leading to admission cannot be safely, efficiently, or effectively	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 272:20-273:2.
black	assessed and/or treated in a less intensive setting due to acute changes in the	<u>Drive Toward Lower Levels of Care</u>	
bullet	member's signs and symptoms, and/or psychosocial and environmental	(see Br. § II.G.3; PFF § X.C)	
(page 8-	factors.		
0036)			

2. Continued Service Criteria (Ex. 8-0036)

\P	Criterion	Why Flawed	Testimony
2nd	Treatment is not primarily for the purpose of providing custodial care.	Maintenance of Function (see Br.	<u>Fishman</u> : Tr. 273:3-9.
black	Services are custodial when they are any of the following:	§ II.G.5; PFF § X.E)	
bullet	 Health-related services provided for the primary purpose of meeting 	Custodial/Improvement (see Br.	
and sub-	the personal needs of the member or maintaining a level of function	§ II.G.8; PFF § X.H)	
bullets	(even if the specific services are considered to be skilled services), as		
(page 8-	opposed to improving that function to an extent that might allow for a		
0036)	more independent existence.		
	 Services that do not require continued administration by trained 		
	medical personnel in order to be delivered safely and effectively.		

XII. AUGUST 2010 CUSTODIAL CARE COVERAGE DETERMINATION GUIDELINE (EX. 10-0003)⁴

\P	Criterion	Why Flawed	Testimony
1st black	United Behavioral Health maintains that optimal clinical outcomes result	Drive Toward Lower Levels of Care	Fishman: Tr. 213:06-214:04; Plakun: Tr.
bullet	when evidence-based treatment is provided in the least restrictive level of	(see Br. § II.G.3; PFF § X.C)	511:25-512:6.
	available care that is structured and intensive enough to safely and adequately		
	treat a member's presenting problem.		
2nd	Patient has been determined to require intensive, 24 hour, specialized	Drive Toward Lower Levels of Care	Fishman: Tr. 213:06-214:04; Plakun: Tr.
black	psychiatric intervention that cannot be provided in a less restrictive setting.	(see Br. § II.G.3; PFF § X.C)	511:25-512:6
bullet			
3rd	United Behavioral Health maintains that treatment of a behavioral health	Maintenance of Function (see Br.	Fishman: Tr. 274:5-275:25; Plakun: Tr.
black	condition in an acute inpatient unit or RTC is not for the purpose of providing	§ II.G.5; PFF § X.E);	557:5-558:23.
bullet	custodial care, but is for the active treatment of a behavioral health condition.	Custodial/Improvement (see Br.	
		§ II.G.8; PFF § X.H)	

⁴ The criteria listed in Sections XII to XVII appear in the "Key Points" section of the Coverage Determination Guidelines for Custodial Care. They also appear in the body of those CDGs; Plaintiffs challenge the provisions cited herein wherever they appear in the CDG, for the same reasons identified here. The criteria listed in Section XVIII appear in the "Coverage Rationale" section of the CDG.

¶	Criterion	Why Flawed	Testimony
4th	Active inpatient or residential treatment is a clinical process involving the 24-	Maintenance of Function (see Br.	<u>Fishman</u> : Tr. 274:5-275:25; <u>Plakun</u> : Tr.
black	hour care of patients that includes assessment, diagnosis, intervention,	§ II.G.5; PFF § X.E);	509:25-510:8. 557:5-558:23.
bullet	evaluation of care, treatment and planning for discharge and aftercare, under	Custodial/Improvement (see Br.	
	the direction of a psychiatrist.	§ II.G.8; PFF § X.H)	
5th	"Active Treatment" in this context is indicated by services that are all of the	Maintenance of Function (see Br.	Fishman: Tr. 274:5-275:25; Plakun: Tr.
black	following:	§ II.G.5; PFF § X.E);	509:25-510:8, 557:5-558:23, 562:11-564:4.
bullet	 Supervised and evaluated by a physician 	Custodial/Improvement (see Br.	
and sub-	 Provided under an individualized treatment or diagnostic plan; 	§ II.G.8; PFF § X.H); Drive Toward	
bullets	o Reasonably expected to improve the patient's condition or for the	Lower Levels of Care (see Br.	
	purpose of diagnosis and	§ II.G.3; PFF § X.C)	
	 Unable to be provided in a less restrictive setting 		
	o Focused on interventions that are based on generally accepted		
	standard medical practice and are known to address the critical		
	presenting problem(s), psychosocial issues and stabilize the patient's		
	condition to the extent that they can be safely treated in a lower level		
	of care.		
6th	Improvement of the patient's condition is indicated by the reduction or	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 274:5-275:25; <u>Plakun</u> : Tr.
black	control of the acute symptoms that necessitated hospitalization or residential	Maintenance of Function (see Br.	563:16-566:16.
bullet	treatment in an acute or Residential Treatment Center.	§ II.G.5; PFF § X.E);	
		Custodial/Improvement (see Br.	
		§ II.G.8; PFF § X.H)	
7th	"Improvement' in this context is measured by weighing the effectiveness of	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 274:5-275:25; <u>Plakun</u> : Tr.
black	treatment and the risk that the member's condition would deteriorate or	Maintenance of Function (see Br.	563:16-566:16; Niewenhous: Tr. 340:16-
bullet	relapse if inpatient or residential treatment were to be discontinued.	§ II.G.5; PFF § X.E);	345:01, 345:04-10, 354:25-357:19.
		Custodial/Improvement (see Br.	
		§ II.G.8; PFF § X.H); <u>Drive Toward</u>	
		Lower Levels of Care (see Br.	
		§ II.G.3; PFF § X.C)	

XIII. <u>DECEMBER 2011 CUSTODIAL CARE COVERAGE DETERMINATION GUIDELINE (EX. 47-0003 TO -0004)</u>

\P	Criterion	Why Flawed	Evidence
1st black	United Behavioral Health maintains that treatment of a behavioral health	Maintenance of Function (see Br.	<u>Fishman</u> : Tr. 274:5-275:25, 276:6-277:16;
bullet	condition in an acute inpatient unit or RTC is not for the purpose of providing	§ II.G.5; PFF § X.E);	<u>Plakun</u> : Tr. 509:25-510:8, 557:5-558:23.
	custodial care, but is for the active treatment of a behavioral health condition.	Custodial/Improvement (see Br.	
		§ II.G.8; PFF § X.H)	
2nd	Custodial care in a psychiatric inpatient or residential setting is the	Maintenance of Function (see Br.	<u>Fishman</u> : Tr. 276:6-277:16; <u>Plakun</u> : Tr.
black	implementation of clinical or non-clinical services that do not seek to cure, or	§ II.G.5; PFF § X.E);	509:25-510:8, 557:5-558:7.
bullet	which are provided during periods when the member's behavioral health	Custodial/Improvement (see Br.	
	condition is not changing, or does not require trained clinical personnel to	§ II.G.8; PFF § X.H)	
	safely deliver services.		
3rd	"Custodial Care" in this context is characterized by the following:	Maintenance of Function (see Br.	Fishman: Tr. 120:12-123:06; Plakun: Tr.
black	o The presenting signs and symptoms of the patient have been	§ II.G.5; PFF § X.E);	509:25-510:8, 557:5-558:7, 560:16-563:23;
bullet	stabilized, resolved, or a baseline level of functioning has been	Custodial/Improvement (see Br.	Niewenhous: Tr. 363:13-364:14, 367:16-
	achieved;	§ II.G.8; PFF § X.H); <u>Drive Toward</u>	368:25
	o The patient is not responding to treatment or otherwise not improving;	Lower Levels of Care (see Br.	
	o The intensity of active treatment provided in an inpatient or residential	§ II.G.3; PFF § X.C)	
	treatment setting is no longer required or services can be safely		
	provided in a less intensive setting.		
	 Examples include respite services, daily living skills instruction, days 		
	awaiting placement, activities that are social and recreational in		
	nature, solely to prevent runaway/truancy or legal problems.		
4th	The provision of Custodial Care by trained behavioral health personnel, such	Maintenance of Function (see Br.	<u>Fishman</u> : Tr. 274:5-275:25, 276:6-277:16;
black	as a psychiatrist or licensed clinician, does not cause the services to be	§ II.G.5; PFF § X.E);	<u>Plakun</u> : Tr. 509:25-510:8, 557:5-558:7,
bullet	classified as skilled services. If the nature of the services can be safely and	Custodial/Improvement (see Br.	560:16-563:23.
	effectively performed by a nontrained person, the services will be considered	§ II.G.8; PFF § X.H)	
	Custodial Care.		
5th	Active treatment in an inpatient or residential treatment setting is a clinical	Maintenance of Function (see Br.	<u>Fishman</u> : Tr. 274:5-275:25, 276:6-277:16;
black	process involving the 24-hour care of patients that includes assessment,	§ II.G.5; PFF § X.E);	<u>Plakun</u> : Tr. 509:25-510:8, 557:5-558:7,
bullet	diagnosis, intervention, evaluation of care, treatment and planning for	Custodial/Improvement (see Br.	562:11-564:4.
	discharge and aftercare, under the direction of a psychiatrist.	§ II.G.8; PFF § X.H)	

¶	Criterion	Why Flawed	Evidence
6th black bullet and sub bullets	"Active Treatment" in this context is indicated by services that are all of the following: O Supervised and evaluated by a physician O Provided under an individualized treatment or diagnostic plan; O Reasonably expected to improve the patient's condition or for the purpose of diagnosis and O Unable to be provided in a less restrictive setting O Focused on interventions that are based on generally accepted standard medical practice and are known to address the critical presenting problem(s), psychosocial issues and stabilize the patient's condition to the extent that they can be safely treated in a lower level of care	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	Fishman: Tr. 276:6-22, 277:6-7; Plakun: Tr. 557:5-558:7, 562:11-564:4,565:5-566:16; Martorana: Tr. 1131:3-9, 1131:13-1132:6.
7th black bullet	Improvement of the patient's condition is indicated by the reduction or control of the acute symptoms that necessitated hospitalization or residential treatment in an acute or Residential Treatment Center.	Acuity (see Br. § II.G.1; PFF § X.A); Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	<u>Fishman</u> : Tr. 276:6-277:5, 277:8-16; <u>Plakun</u> : 563:16-566:16, 565:21-22, 566:5-16,; <u>Martorana</u> : Tr. 1093:5-8.
8th black bullet	"Improvement" in this context is measured by weighing the effectiveness of treatment and the risk that the member's condition would deteriorate or relapse if inpatient or residential treatment were to be discontinued.	Acuity (see Br. § II.G.1; PFF § X.A); Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	<u>Fishman</u> : Tr. 274:5-275:25, 276:6-277:16; <u>Plakun</u> : Tr. 563:16-566:16; <u>Martorana</u> : Tr. 1093:5-8.
9th black bullet	United Behavioral Health maintains that inpatient or residential treatment should be consistent with nationally recognized scientific evidence as available, prevailing medical standards and clinical guidelines and cannot be provided in a less restrictive setting.	Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	<u>Fishman</u> : Tr. 213:06-214:04; <u>Plakun</u> : Tr. 511:25-512:6.

XIV. JANUARY 2013 CUSTODIAL CARE COVERAGE DETERMINATION GUIDELINE (EX. 84-0003)

¶	Criterion	Why Flawed	Evidence
1st black	Custodial Care in a psychiatric inpatient or residential setting is the	Maintenance of Function (see Br.	Fishman: Tr. 278:1-278:6; Plakun: Tr.
bullet	implementation of clinical or non-clinical services that do not seek to cure, or	§ II.G.5; PFF § X.E);	509:25-510:8, 557:5-558:23.
	which are provided during periods when the member's behavioral health	Custodial/Improvement (see Br.	
	condition is not changing, or does not require trained clinical personnel to	§ II.G.8; PFF § X.H)	
	safely deliver services (Certificate of Coverage (COC), 2011).		
2nd	"Custodial Care" in this context is characterized by the following:	Maintenance of Function (see Br.	Fishman: Tr. 120:12-123:06; Plakun: Tr.
black	o The presenting signs and symptoms of the patient have been	§ II.G.5; PFF § X.E);	509:25-510:8, 557:5-558:23, 560:16-563:23.
bullet	stabilized, resolved, or a baseline level of functioning has been	Custodial/Improvement (see Br.	
and sub-	achieved;	§ II.G.8; PFF § X.H); <u>Drive Toward</u>	
bullets	o The patient is not responding to treatment or otherwise not improving;	Lower Levels of Care (see Br.	
	o The intensity of active treatment provided in an inpatient or residential	§ II.G.3; PFF § X.C)	
	treatment setting is no longer required or services can be safely		
	provided in a less intensive setting.		
3rd	Examples of Custodial Care include respite services, daily living skills	Maintenance of Function (see Br.	Fishman: Tr. 278:1-278:6; Plakun: Tr.
black	instruction, days awaiting placement, activities that are social and recreational	§ II.G.5; PFF § X.E);	560:16-563:23.
bullet	in nature, or solely to prevent runaway/truancy or legal problems (Centers for	Custodial/Improvement (see Br.	
	Medicare and Medicaid Services, Benefit Manual, (CMS), 2010).	§ II.G.8; PFF § X.H)	
4th	The provision of Custodial Care by trained behavioral health personnel, such	Maintenance of Function (see Br.	Fishman: Tr. 278:1-278:6; Plakun: Tr.
black	as a psychiatrist or licensed clinician, does not cause the services to be	§ II.G.5; PFF § X.E);	560:16-563:23.
bullet	classified as skilled services. If the nature of the services can be safely and	Custodial/Improvement (see Br.	
	effectively performed by a non-trained person, the services will be considered	§ II.G.8; PFF § X.H)	
	Custodial Care.		
5th	Active treatment in an inpatient or residential treatment setting is a clinical	Maintenance of Function (see Br.	Fishman: Tr. 278:1-278:6; Plakun: Tr. 562:2-
black	process involving the 24-hour care of patients that includes assessment,	§ II.G.5; PFF § X.E);	563:18.
bullet	diagnosis, intervention, evaluation of care, treatment and planning for	Custodial/Improvement (see Br.	
	discharge and aftercare, under the direction of a psychiatrist.	§ II.G.8; PFF § X.H)	

¶	Criterion	Why Flawed	Evidence
6th black bullet and sub bullets	"Active Treatment" in this context is indicated by services that are <u>all</u> of the following (CMS, 2010): Output Supervised and evaluated by a physician; Provided under an individualized treatment or diagnostic plan; Reasonably expected to improve the member's condition or for the purpose of diagnosis; Unable to be provided in a less restrictive setting; and Focused on interventions that are based on generally accepted standard medical practice and are known to address the critical presenting problem(s), psychosocial issues and stabilize the member's condition to the extent that they can be safely treated in a lower level of care.	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	Fishman: Tr. 278:1-278:6; Plakun: Tr. 562:11-564:4, 565:5-13, 566:17-23.
7th black bullet	Improvement of the patient's condition is indicated by the reduction or control of the acute symptoms that necessitated hospitalization or residential treatment in an acute or Residential Treatment Center.	Acuity (see Br. § II.G.1; PFF § X.A); Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	<u>Fishman</u> : Tr. 276:6-277:5, 277:8-16; <u>Plakun</u> : 563:16-566:16, 565:21-22, 566:5-16.
8th black bullet	"Improvement" in this context is measured by weighing the effectiveness of treatment and the risk that the member's condition would deteriorate or relapse if inpatient or residential treatment were to be discontinued.	Acuity (see Br. § II.G.1; PFF § X.A); Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	<u>Fishman</u> : Tr. 278:1-278:6; <u>Plakun</u> : Tr. 563:16-566:16; <u>Martorana</u> : Tr. 1093:5-8.
9th black bullet	Optum maintains that inpatient or residential treatment should be consistent with nationally recognized scientific evidence as available, prevailing medical standards and clinical guidelines and cannot be provided in a less restrictive setting.	Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	Fishman: Tr. 213:06-214:04; Plakun: Tr. 511:25-512:6.

XV. FEBRUARY 2014 CUSTODIAL CARE COVERAGE DETERMINATION GUIDELINE (EX. 108-0003)

¶	Criterion	Why Flawed	Evidence
1st black bullet	Custodial Care in a psychiatric inpatient or residential setting is the implementation of clinical or non-clinical services that do not seek to cure, or which are provided during periods when the member's behavioral health condition is not changing, or does not require trained clinical personnel to safely deliver services (Certificate of Coverage (COC), 2001, 2007, 2009, 2011).	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	<u>Fishman</u> : Tr. 278:7-279:3; <u>Plakun</u> : Tr. 509:25-510:8, 557:5-558:23.
2nd black bullet and sub- bullets	 "Custodial Care" in this context is characterized by the following (COC, 2001, 2007, 2009, 2011): The presenting signs and symptoms of the member have been stabilized, resolved, or a baseline level of functioning has been achieved; or The member is not responding to treatment or otherwise not improving; or The intensity of active treatment provided in an inpatient or residential treatment setting is no longer required or services can be safely provided in a less intensive setting. 	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	Fishman: Tr. 120:12-123:06, 278:7-20, 278:7-279:3; Plakun: Tr. 560:16-563:23.
3rd black bullet	Examples of Custodial Care include respite services, daily living skills instruction, days awaiting placement, activities that are social and recreational in nature, or solely to prevent runaway/truancy or legal problems (Centers for Medicare and Medicaid Services, Benefit Manual, (CMS), 2013).	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	<u>Fishman</u> : Tr. 278:7-9, 278:21-22; <u>Plakun</u> : Tr. 560:16-563:23.
4th black bullet	The provision of Custodial Care by trained behavioral health personnel, such as a psychiatrist or licensed clinician, does not cause the services to be classified as skilled services. If the nature of the services can be safely and effectively performed by a nontrained person, the services will be considered Custodial Care.	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	<u>Fishman</u> : Tr. 278:7-279:3; <u>Plakun</u> : Tr. 560:16-563:23.

¶	Criterion	Why Flawed	Evidence
5th black bullet	Active Treatment in an inpatient or residential treatment setting is a clinical process involving the 24-hour care of members that includes assessment, diagnosis, intervention, evaluation of care, treatment and planning for discharge and aftercare under the direction of a psychiatrist (CMS, 2013).	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	<u>Fishman</u> : Tr. 278:7-279:3; <u>Plakun</u> : Tr. 562:11-564:4.
6th black bullet and sub- bullets	 "Active Treatment" in this context is indicated by services that are all of the following (CMS, 2013): Supervised and evaluated by a physician; Provided under an individualized treatment or diagnostic plan; Reasonably expected to improve the member's condition or for the purpose of diagnosis; Unable to be provided in a less restrictive setting; and Focused on interventions that are based on generally accepted standard medical practice and are known to address the critical presenting problem(s), psychosocial issues and stabilize the member's condition to the extent that they can be safely treated in a lower level of care. 	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	<u>Fishman</u> : Tr. 278:7-9, 278:23-24; <u>Plakun</u> : Tr. 562:11-564:4.
7th black bullet	<i>Improvement</i> of the member's condition is indicated by the reduction or control of the acute symptoms that necessitated hospitalization or residential treatment (CMS, 2013).	Acuity (see Br. § II.G.1; PFF § X.A); Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	<u>Fishman</u> : Tr. 278:7-9, 278:25-279:3; <u>Plakun</u> : Tr. 563:16-566:16;
8th black bullet	"Improvement" in this context is measured by weighing the effectiveness of treatment and the risk that the member's condition would deteriorate or relapse if inpatient or residential treatment were to be discontinued (CMS, 2013).	Acuity (see Br. § II.G.1; PFF § X.A); Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	<u>Fishman</u> : Tr. 278:7-279:3; <u>Plakun</u> : Tr. 563:16-566:16.

\P	Criterion	Why Flawed	Evidence
9th	Optum maintains that inpatient or residential treatment should be consistent	Drive Toward Lower Levels of Care	Fishman: Tr. 213:06-214:04; Plakun: Tr.
black	with nationally recognized scientific evidence as available, prevailing medical	(see Br. § II.G.3; PFF § X.C)	511:25-512:6.
bullet	standards and clinical guidelines and cannot be provided in a less restrictive		
	setting.		

XVI. MARCH 2015 CUSTODIAL CARE COVERAGE DETERMINATION GUIDELINE (EX. 148-0003)

¶	Criterion	Why Flawed	Evidence
1st black	Services provided in psychiatric inpatient and residential treatment	Custodial/Improvement (see Br.	Fishman: Tr. 120:12-121:13, 120:12-123:06;
bullet	settings that are not active and are solely for the purpose of Custodial	§ II.G.8; PFF § X.H);	<u>Plakun</u> : Tr. 560:16-563:23; <u>Niewenhous</u> : Tr.
	Care as defined below are excluded.		369:1-371:3.
2nd	Custodial Care in a psychiatric inpatient or residential setting is any of the	Maintenance of Function (see Br.	Fishman: Tr. 120:12-121:13, 120:12-123:06;
black	following (Certificate of Coverage (2011):	§ II.G.5; PFF § X.E);	<u>Plakun</u> : Tr. 560:16-563:23; <u>Niewenhous</u> : Tr.
bullet	 Non-health-related services, such as assistance in activities of daily 	Custodial/Improvement (see Br.	369:1-371:3.
and sub-	living (examples include feeding, dressing, bathing, transferring and	§ II.G.8; PFF § X.H); <u>Drive Toward</u>	
bullets	ambulating).	Lower Levels of Care (see Br.	
	 Health-related services that are provided for the primary purpose of 	§ II.G.3; PFF § X.C)	
	meeting the personal needs of the patient or maintaining a level of		
	function (even if the specific services are considered to be skilled		
	services), as opposed to improving that function to an extent that		
	might allow for a more independent existence.		
	 Services that do not require continued administration by trained 		
	medical personnel in order to be delivered safely and effectively.		

\P	Criterion	Why Flawed	Evidence
3rd black bullet and sub- bullets	Active Treatment in an inpatient or residential treatment setting is a clinical process involving the 24-hour care of members that includes assessment, diagnosis, intervention, evaluation of care, treatment and planning for discharge and aftercare under the direction of a psychiatrist (CMS Psychiatric Inpatient Local Coverage Determinations, 2014). O Active Treatment is indicated by services that are all of the following (CMS Benefit Policy Manual, Chapter 2, 30.2.2.1, 2014): Supervised and evaluated by a physician; Provided under an individualized treatment or diagnostic plan; Reasonably expected to improve the member's condition or for	Maintenance of Function (see Br. § II.G.5; PFF § X.E); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C); Custodial/Improvement (see Br. § II.G.8; PFF § X.H)	Fishman: Tr. 121:18-122:07, 122:19-123:6; Plakun: Tr. 562:11-564:4, 562:11-564:4.
	the purpose of diagnosis; Unable to be provided in a less restrictive setting; and Focused on interventions that are based on generally accepted standard medical practice and are known to address the critical presenting problem(s), psychosocial issues and stabilize the member's condition to the extent that they can be safely treated in a lower level of care.		
4th black bullet and sub- bullet	Improvement of the member's condition is indicated by the reduction or control of the acute symptoms that necessitated hospitalization or residential treatment (CMS Psychiatric Inpatient Local Coverage Determinations, 2014). o Improvement is measured by weighing the effectiveness of treatment and the risk that the member's condition would deteriorate or relapse if inpatient or residential treatment were to be discontinued (CMS Psychiatric Inpatient Local Coverage Determinations, 2014).	Acuity (see Br. § II.G.1; PFF § X.A); Maintenance of Function (see Br. § II.G.5; PFF § X.E); Custodial/Improvement (see Br. § II.G.8; PFF § X.H); Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	<u>Fishman</u> : Tr. 123:16-23; <u>Plakun</u> : Tr. 563:16-23, 564:5-15;
5th black bullet	Optum maintains that inpatient or residential treatment should be consistent with nationally recognized scientific evidence as available, prevailing medical standards and clinical guidelines and cannot be provided in a less restrictive setting.	Drive Toward Lower Levels of Care (see Br. § II.G.3; PFF § X.C)	<u>Fishman</u> : Tr. 213:06-214:04; <u>Plakun</u> : Tr. 511:25-512:6.

XVII. <u>APRIL 2016 CUSTODIAL CARE COVERAGE DETERMINATION GUIDELINE (EX. 195)</u>

¶	Criterion	Why Flawed	Evidence
1st black	Services provided in psychiatric inpatient and residential treatment	Custodial/Improvement (see Br.	Fishman: Tr. 120:12-123:06, 279:04-14;
bullet	settings that are not active and are solely for the purpose of Custodial	§ II.G.8; PFF § X.H);	<u>Plakun</u> : Tr. 509:25-510:8, 557:5-558:23,
	Care as defined below are excluded.		560:16-563:23.
2nd	Custodial Care in a psychiatric inpatient or residential setting is any of the	Maintenance of Function (see Br.	<u>Fishman</u> : Tr. 120:12-123:06, 279:04-14;
black	following (Certificate of Coverage (2011):	§ II.G.5; PFF § X.E);	<u>Plakun</u> : Tr. 509:25-510:8, 557:5-558:23,
bullet &	 Non-health-related services, such as assistance in activities of daily 	Custodial/Improvement (see Br.	560:16-563:23.
sub-	living (examples include feeding, dressing, bathing, transferring and	§ II.G.8; PFF § X.H); <u>Drive Toward</u>	
bullets	ambulating).	Lower Levels of Care (see Br.	
	 Health-related services that are provided for the primary purpose of 	§ II.G.3; PFF § X.C)	
	meeting the personal needs of the patient or maintaining a level of		
	function (even if the specific services are considered to be skilled		
	services), as opposed to improving that function to an extent that		
	might allow for a more independent existence.		
	o Services that do not require continued administration by trained		
	medical personnel in order to be delivered safely and effectively.		
3rd	Active Treatment in an inpatient or residential treatment setting is a clinical	Maintenance of Function (see Br.	Fishman: Tr. 279:04-06; 279:15-19; Plakun:
black	process involving the 24-hour care of members that includes assessment,	§ II.G.5; PFF § X.E);	Tr. 562:11-564:4.
bullet &	diagnosis, intervention, evaluation of care, treatment and planning for	Custodial/Improvement (see Br.	
sub-	discharge and aftercare under the direction of a psychiatrist that cannot be	§ II.G.8; PFF § X.H); <u>Drive Toward</u>	
bullets	managed in a less restrictive setting (CMS Psychiatric Inpatient Local	Lower Levels of Care (see Br.	
	Coverage Determinations, 2016)	§ II.G.3; PFF § X.C)	
	o Active Treatment is indicated by services that are <u>all</u> of the following		
	(CMS Benefit Policy Manual, Chapter 2, 30.2.2.1, Retrieved March,		
	2016): Supervised and evaluated by a physician:		
	Supervised and evaluated by a physician,		
	 Provided under an individualized treatment or diagnostic plan; and 		
	 Reasonably expected to improve the member's condition or for 		
	the purpose of diagnosis.		
	l the purpose of diagnosis.		

\P	Criterion	Why Flawed	Evidence
4th	Improvement of the member's condition is indicated by the reduction or	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 279:04-06; 279:20-22; <u>Plakun</u> :
black	control of the acute symptoms that necessitated hospitalization or residential	Maintenance of Function (see Br.	Tr. 563:16-566:16.
bullet &	treatment (CMS Psychiatric Inpatient Local Coverage Determinations, 2016)	§ II.G.5; PFF § X.E);	
sub-	o Improvement is measured by weighing the effectiveness of treatment	Custodial/Improvement (see Br.	
bullets	and the risk that the members condition would deteriorate or relapse if	§ II.G.8; PFF § X.H); Drive Toward	
	inpatient or residential treatment were to be discontinued (CMS	Lower Levels of Care (see Br.	
	Psychiatric Inpatient Local Coverage Determinations, 2016)	§ II.G.3; PFF § X.C)	
5th	Optum maintains that inpatient or residential treatment should be consistent	Drive Toward Lower Levels of Care	<u>Fishman</u> : Tr. 213:06-214:04; <u>Plakun</u> : Tr.
black	with nationally recognized scientific evidence as available, prevailing medical	(see Br. § II.G.3; PFF § X.C)	511:25-512:6.
bullet	standards and clinical guidelines and cannot be provided in a less restrictive		
	setting (Certificate of Coverage, 2011).		

XVIII. MARCH 2017 CUSTODIAL CARE COVERAGE DETERMINATION GUIDELINE (EX. 221)

¶	Criterion	Why Flawed	Evidence
1st¶	Services provided in psychiatric inpatient and residential treatment settings	Custodial/Improvement (see Br.	Fishman: Tr. 120:12-123:06, 279:24-280:12,
	that are not active and are solely for the purpose of Custodial Care as defined	§ II.G.8; PFF § X.H);	279:24-280:04; 280:13-18; <u>Plakun</u> : Tr.
	below are excluded.		509:25-510:8, 557:5-558:23, 560:16-563:23.
2nd ¶	Custodial Care in a psychiatric inpatient or residential setting is any of the	Maintenance of Function (see Br.	Fishman: Tr. 120:12-123:06, 279:24-280:12,
	following (Certificate of Coverage, 2011):	§ II.G.5; PFF § X.E);	279:24-280:04; 280:13-18; <u>Plakun</u> : Tr.
	Non-health-related services, such as assistance in activities of daily	Custodial/Improvement (see Br.	509:25-510:8, 557:5-558:23, 560:16-563:23.
	living (examples include feeding, dressing, bathing, transferring, and	§ II.G.8; PFF § X.H); <u>Drive Toward</u>	
	ambulating).	Lower Levels of Care (see Br.	
	Health-related services that are provided for the primary purpose of	§ II.G.3; PFF § X.C)	
	meeting the personal needs of the patient or maintaining a level of		
	function (even if the specific services are considered to be skilled		
	services), as opposed to improving that function to an extent that		
	might allow for a more independent existence.		
	Services that do not require continued administration by trained		
	medical personnel in order to be delivered safely and effectively.		

\P	Criterion	Why Flawed	Evidence
3rd ¶	Active Treatment in an inpatient or residential treatment setting is a clinical	Maintenance of Function (see Br.	<u>Fishman</u> : Tr. 279:24-280:04, 280:13-18,
	process involving the 24-hour care of members that includes assessment,	§ II.G.5; PFF § X.E);	279:24-280:04; 280:19-25; <u>Plakun</u> : Tr.
	diagnosis, intervention, evaluation of care, treatment and planning for	Custodial/Improvement (see Br.	562:11-564:4.
	discharge and aftercare under the direction of a psychiatrist that cannot be	§ II.G.8; PFF § X.H); <u>Drive Toward</u>	
	managed in a less restrictive setting (CMS Psychiatric Inpatient Local	Lower Levels of Care (see Br.	
	Coverage Determinations, 2016).	§ II.G.3; PFF § X.C)	
	 Active Treatment is indicated by services that are all of the following 		
	(CMS Benefit Policy Manual, Chapter 2, 30.2.2.1):		
	 Supervised and evaluated by a physician; 		
	 Provided under an individualized treatment or diagnostic plan; 		
	and		
	o Reasonably expected to improve the member's condition or for		
	the purpose of diagnosis.		
4th ¶	Improvement of the member's condition is indicated by the reduction or	Acuity (see Br. § II.G.1; PFF § X.A);	<u>Fishman</u> : Tr. 279:24-280:04; 281:01-06;
	control of the acute symptoms that necessitated hospitalization or residential	Maintenance of Function (see Br.	<u>Plakun</u> : Tr. 563:16-566:16.
	treatment (CMS Psychiatric Inpatient Local Coverage Determinations, 2016).	§ II.G.5; PFF § X.E);	
	 Improvement is measured by weighing the effectiveness of treatment 	Custodial/Improvement (see Br.	
	and the risk that the member's condition would deteriorate or relapse	§ II.G.8; PFF § X.H); <u>Drive Toward</u>	
	if inpatient or residential treatment were to be discontinued (CMS	Lower Levels of Care (see Br.	
	Psychiatric Inpatient Local Coverage Determinations, 2016).	§ II.G.3; PFF § X.C)	
5th ¶	Optum maintains that inpatient or residential treatment should be consistent	Drive Toward Lower Levels of Care	Fishman: Tr. 213:06-214:04; Plakun: Tr.
	with nationally recognized scientific evidence as available, prevailing medical	(see Br. § II.G.3; PFF § X.C)	511:25-512:6.
	standards and clinical guidelines and cannot be provided in a less restrictive		
	setting (Certificate of Coverage, 2011).		